

Home and Community Based Services - Frail Elderly Provider Handbook



December 2010

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Section 1: Program Description

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HCBS/FE:

- Provides community based services as an alternative to nursing facility care,
- Promotes independence in the community setting, and
- Ensures residency in the most integrated environment

In Kansas, if customers qualify for nursing facility care, they may choose home and community based services, if available, or enter a nursing facility

ELIGIBILITY:

- Age – customer must be 65 years of age or older
- Customer Choice of HCBS/FE (Customers must choose and accept HCBS and have the option to refuse)
- Functional Need – based on the Long Term Care Threshold Guide of the Uniform Assessment Instrument (UAI) – determined by the TCM
- Financial Need – Medicaid Eligibility(TXIX benefit plan)– determined by SRS
- Available Service Providers
- Waiver Constraints (would be a waiting list, service suspensions, etc)

SERVICES AVAILABLE:

- Adult Day Care
- Assistive Technology**
- Attendant Care Services (provider directed or self directed)
- Comprehensive Support** (provider directed or self directed)
- Financial Management Services
- Home Telehealth
- Medication Reminder
- Nurse Evaluation Visit
- Oral Health Services**
- Personal Emergency Response (installation and rental)
- Sleep Cycle Support** (self directed only)
- Wellness Monitoring

** denotes services currently suspended and only accessed if a crisis exception is approved by KDOA.

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Section 2: Service Implementation

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- Referral is made to the FE Case Management Entity (refer to the list of CMEs in the “Miscellaneous Information” section) of the customer’s choice
 - Basic information is gathered to identify the customer and to indicate what the initial needs of the customer are
- Referrals for HCBS/FE can come from:
 - SRS eligibility workers
 - APS
 - Individuals or families
 - Community agencies / facilities
- Once referral is received a TCM is assigned to the case
 - TCM will contact the customer or representative to begin the assessment process
 - Completes the Uniform Assessment Instrument within 6 working days of referral
 - Determines Long Term Care Threshold score (functional eligibility)
 - Plan of Care (POC) start date determined
 - POC service(s) and hours must be prior authorized by KDOA
 - POC implemented and providers begin rendering services
- SRS determines financial (TXIX) eligibility
 - Customers/Families need to be ready to provide the following information with the application:
 - Proof of where you live
 - Proof of age and identity
 - Proof of citizenship for those who want to receive benefits
 - Proof of non-citizen status for those who want to receive benefits
 - Dependent care bills and receipts
 - Proof of child support and/or alimony paid or received
 - Proof of income (pay stubs, earning statements, rental property/sales contracts, government payments, workers compensation, pensions, and other)
 - If self-employed, federal income tax returns, bookkeeping records, sales, and expenditure records
 - Life insurance and burial plans
 - Rent receipt/house payment (including insurance and property taxes)
 - Proof of medical expenses such as medication, doctor bills, and hospital bills
 - Health insurance cards and premium information
 - Bank statements for checking accounts, savings accounts, or stocks/bonds/mutual funds
 - Proof of trusts and annuities
 - Other
 - If assistance is needed to complete the application contact SRS at 1-888-369-4777
 - Medicaid application is valid up to 45 days
 - It may take a longer time period to determine financial eligibility if there has been a transfer of property, out of state insurance policies, etc.
 - Medicaid (TXIX) is a monthly eligibility – if eligibility is determined on October 23rd it will be effective October 1st.
- The functional and financial determinations may be processed during the same time frame meaning that one does not have to be completed in order to begin the next.
- POC’s are to be implemented within 7 working days of financial and functional eligibility determination
 - HCBS/FE does not backdate authorization of services so the start date of services will be dependent upon the TCM being notified by SRS of financial eligibility and submitting the POC for KDOA approval.
 - Customers are not authorized to receive HCBS/FE services until the TCM sends the provider the CSW, POC, and NOA.

- Plan of Care Development for all customers:
 - Services are based upon assessed need
 - When others reside with the customer the TCM shall discuss what assistance may be provided as informal support
 - The TCM negotiates with providers regarding the rate and hours of service for the customer to ensure proper staffing availability
 - Authorization is obtained from a KDOA POC approver
 - Providers are sent the POC, CSW, and NOA
- Assisted Living, Residential Health Care, Home Plus and Boarding Care Home hours are additionally determined by:
 - Customer negotiates Room and Board rate with facility apart from the POC process
 - TCM reviews the Negotiated Service Agreement (NSA) and Functional Capacity Screen (FCS)
 - TCM reviews time studies (e.g., meal prep, laundry) to support the authorized service hours
 - TCM, along with the customer and facility staff, develop the POC
- Long Term Care (LTC) Insurance and Veterans Benefits
 - The TCM must complete the CSW and POC based on customer need.
 - The TCM will list all the services/tasks to be provided to the customer on the CSW.
 - Those services/tasks funded by LTC Insurance or Veterans Benefits shall be listed in the informal column.
- TCM's authorize hours of service necessary to maintain the customer's health and welfare
 - Room and Board rates are to be negotiated separate and apart from POC costs in facility settings
 - POC's shall not be written with the intent to match or exceed the private pay room rate in facility settings
 - Time authorized for Attendant Care is based on need and task specific
 - Time for certain tasks will be adjusted in situations where there is more than the customer residing in the home/facility. For example:
 - If there are two customers living in a home or sharing a room at a facility the time for housekeeping will be split between both POCs
 - If there are two customers needing assistance with eating and the staff is helping four people for a total of 40 minutes then the time for eating would be authorized for 10 minutes per customer on the CSW
 - Monitor any change in condition for 2 weeks or so before contacting TCM



HCBS/Frail Elderly New Customer – Medicaid Established

Approx. 13 days

Dec. 1	Dec. 6	Dec. 9	Dec. 12	Dec. 13	Dec 15
Referral made to the CME. TCM is assigned to case.	TCM makes a visit to the customer's home and completes the UAI. Customer Service Worksheet and Plan of Care are developed.	UAI and POC is data entered into KAMIS for approval. (KDOA has 3 days for level I and 7 days for Level II or III POCs.)	KDOA approves the POC with a 12/15 start date.	TCM sends NOA, CSW and POC to customer and provider for services to start 12/15.	Provider starts services.

HCBS/Frail Elderly New Customer – No Medicaid Established

Approx. 53 days

Dec. 1	Dec. 3	Dec. 6	Dec. 7	Jan. 22	Jan. 23	Jan. 26	Jan. 28	Feb. 1
Referral made to SRS for Medicaid application.	Referral made to CME. TCM is assigned to case.	TCM makes a visit to the customer's home and completes the UAI. CSW and POC are developed.	Medicaid application completed and turned into SRS. (SRS has up to 45 days to process application.)	SRS determines Medicaid eligibility and notifies TCM.	CME data enters UAI and POC into KAMIS for a 2/1 start date. (KDOA has 3 days for level I and 7 days for Level II or III POCs.)	KDOA approves the POC with a 2/1 start date.	TCM sends the NOA, CSW, POC opening the case to the customer and provider.	Provider starts services.

HCBS/Frail Elderly Existing Facility Customer – POC Change

Approx. 13 days

Dec. 1	Dec. 6	Dec. 8	Dec. 11	Dec. 12	Dec. 13
Provider contacts the TCM to indicate a need for a change to services.	TCM makes a home visit to review customer's needs. Documentation, notes, functional capacity screen and negotiated service agreement are to be reviewed by TCM. POC and CSW updated to reflect documented increased need.	CME data enters POC into KAMIS system for a 12/13 start date.	KDOA approves the POC on KAMIS with a 12/13 start date.	TCM sends the NOA, CSW and POC changing services 12/13 to the customer and provider.	Provider follows updated CSW and NOA.

HCBS/Frail Elderly Existing Facility Customer – POC Change

(qualifies for “effective dating” – means the POC may be authorized before approved on the KAMIS) – Approx. 6 days

Dec. 1	Dec. 6	Dec. 6	Dec. 6	Dec. 6	Dec. 9
Facility contacts TCM to indicate customer has increased needs.	TCM makes a home visit and reviews documentation, notes, FCS, NSA. Customer is determined to have increased needs. POC and CSW updated to reflect needs.	TCM e-mails KDOA to request effective dating for 12/6. KDOA responds approving effective dating as requested.	TCM sends CSW, POC, and NOA, increasing services effective 12/6 to customer and provider. TCM data enters POC into KAMIS with 12/6 start date.	Facility follows updated CSW and NOA.	KDOA crosschecks to ensure effective dating approval was given. KDOA approves POC for 12/6 start date.

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Section 3: Client Obligations

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- Client obligation is the amount of income over the Protected Income Level (PIL), determined by the SRS eligibility worker, that the customer must pay to the provider each month for HCBS/FE services
- Currently, the PIL is \$727 / month.
- Examples:

Customer Income	\$500
PIL	<u>\$727</u>
Client Obligation	\$ 0/month
Customer Income	\$830
PIL	<u>\$727</u>
Client Obligation	\$103/month
Customer Income	\$1500
PIL	<u>\$ 727</u>
Client Obligation	\$ 773/month
- SRS eligibility worker can assign income to allow the customer to pay out of pocket medical expenses which may reduce or eliminate a client obligation
- If the POC cost for HCBS/FE services is less than a customer's client obligation, then the customer is not eligible for HCBS/FE and the POC is not valid
 - For example:
 - POC cost is \$800 per month
 - Client Obligation is \$900 per month
- Customers wouldn't pay the entire obligation when the services received are not in excess of their obligation amount
 - For example, the customer received \$250 worth of services and has a \$375 client ob – the customer would only pay \$250 for services received
- The Client Obligation will be automatically deducted from the total amount billed as the claim processes
 - The obligation will be deducted from the first claim billed each month regardless of the service billed
- It is the provider's responsibility to collect the monthly client obligation. Promptly contact the customer's TCM if the customer falls behind in payments.
 - Regardless what services or service method the customer is receiving.
 - It is not acceptable or appropriate to withhold the client obligation from workers paychecks as it is the customer's responsibility to pay this obligation as a condition of receiving services on the HCBS program.
- A customer may pay the client obligation due for a particular month before the end of that month. For example; the customer has a \$945 client obligation for October. The provider may request this be paid by October 15th.
 - If the customer pays the client obligation in full but does not end up receiving services equal to or above the client obligation the difference must be immediately refunded or credited to the customer.

- The provider must have a policy in place to identify at what point a client obligation payment is considered to be late or past due.
- If the provider is going to withdraw being a provider due to non-payment of the client obligation please remember per the KMAP HCBS Provider Certification Statement (6/08): If services are to be terminated by the provider, written notice of termination shall be given to the beneficiary or the beneficiary's family, except in instances of death or institutionalization. The notice shall be served by delivering a copy of the notice to the beneficiary and the case manager or by mailing a copy of the notice to the beneficiary at the beneficiary's last known address. Notice shall be served at least 30 calendar days prior to the effective date of the termination, except in cases of violent or sexually inappropriate behavior. The notice shall include the reasons for and the effective date of the termination.

Section 4: Service Descriptions

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ADULT DAY CARE

DEFINITION:

This service is designed to maintain optimal physical and social functioning for HCBS customers. This service provides a balance of activities to meet the interrelated needs and interests (e.g., social, intellectual, cultural, economic, emotional, physical) of HCBS customers.

This service includes:

Basic nursing care as delegated or provided by a licensed nurse and as identified in the service plan. Daily supervision/physical assistance with certain activities of daily living limited to eating, mobility and may include transfer, bathing and dressing as identified in the Customer Service Worksheet (CSW).

This service shall not duplicate other waiver services.

LIMITATIONS:

- Service may not be provided in the customer's own residence.
- Customer's living in an assisted living facility, residential health care facility, or a home plus are not eligible for this service.
- Service is limited to a maximum of two units of service per day, one or more days per week.
- A registered nurse (RN) must be available on-call as needed.
- Special dietary needs are not required but may be provided as negotiated on an individual basis between the customer and the provider. No more than two meals per day may be provided.
- Transfer, bathing, toileting and dressing are not required but may be provided as negotiated on an individual basis between the customer and the provider as identified in the individual's plan of care and if the provider is capable of this scope of service.
- Therapies (physical, occupational and speech) and transportation are not covered under this service but may be covered through regular Medicaid.

ENROLLMENT:

Providers must be licensed by the Kansas Department on Aging. Licensed entities include free-standing Adult Day Care Facilities, Nursing Facilities, Assisted Living Facilities, Residential Health Care Facilities, and Home Plus.

REIMBURSEMENT:

One unit = one to five hours and no more than two units in a twenty-four hour period.

Maximum unit cost = \$21.93

Procedure Code = S5101

The reimbursement for this service is defined as a range to allow flexibility and efficiency in service delivery; provide consistency with other Medicaid services such as Home Health Aide visits; and to meet customer preferences in providers and service delivery methods. The customer will be monitored through case management. This will ensure providers deliver the necessary scope of service as agreed and defined in the plan of care regardless of the length of time needed to deliver service.

ASSISTIVE TECHNOLOGY

DEFINITION:

Assistive technology (AT) consists of either one of the following:

Purchase of an item or piece of equipment that improves or assists with functional capabilities including, but not limited to, grab bars, bath benches, toilet risers, and lift chairs

Purchase and installation of home modifications that improve mobility including, but not limited to, ramps, widening of doorways, bathroom modifications, and railings.

LIMITATIONS:

- AT is limited to the customer's assessed level of service need, as specified in the customer's plan of care, subject to an exception process established by the State. All customers are held to the same criteria when qualifying for an exception in accordance with the established Kansas Department on Aging (KDOA) policies and guidelines.
- All AT purchases require prior authorization from KDOA.
- This service must be cost-effective and appropriate to the customer's needs.
- This service is limited to a lifetime maximum of \$7,500.
- AT funded by other waiver programs is calculated into the lifetime maximum.
- Payment is for the item or modification and does not include administrative costs.
- Repairs or maintenance are not allowed for home modifications or assistive items.
- Home modification includes only those adaptations that are necessary to accommodate the mobility of the customer.
- Replacements and duplicate items shall not be covered for the first twelve months after the purchase date of the item.
- For home modifications to be authorized in a home not owned by the customer the owner/landlord must agree, in writing, to maintain the modifications for the time period in which the HCBS/FE customer resides there.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- External modifications (such as, porches, decks, and landings) will only be allowed to the extent required to complete the approved request.
- Home accessibility adaptations cannot be furnished to adapt living arrangements that are owned or leased by providers of waiver services
- If Medicare covers an AT item but denies authorization, HCBS/FE will cover only the difference between the standardized Medicare portion of the item and the actual purchase price.

ENROLLMENT:

Any business, agency, or company that furnishes assistive technology items or services is eligible to enroll. Companies chosen to provide adaptations to housing structures must be licensed or certified by the county or city and must perform all work according to existing building codes. If the company is not licensed or certified, then a letter from the county or city must be provided stating licensure or certification is not required.

REIMBURSEMENT:

One unit = One Purchase
Procedure Code = T2029

ATTENDANT CARE SERVICES

DEFINITION:

There are two methods of providing attendant care services, provider directed and self-directed. Customers are given the option to self-direct their attendant care services. A combination of service providers and types of attendant care, either provider directed and/or self-directed, may be used to meet the approved Plan of Care.

ATTENDANT CARE SERVICES - PROVIDER DIRECTED

Attendant care services provide supervision and/or physical assistance with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) for individuals who are unable to perform one or more activities independently. (K.S.A. 65-6201). Attendant care services may be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

There are three levels of provider directed attendant care services, which are referred to as Level I, Level II, and Level III. A combination of Level I (Service A & B) and Level II (Service C & D) can be utilized in the development of the Plan of Care. If a combination of Level I and Level II services are included in the Plan of Care, the Level II rate shall be paid if both levels of care are provided by the same provider. For Boarding Care Homes, the tasks authorized on the POC must fall within the licensing regulations. Level III will be utilized in the development of the POC for those participants residing in adult care homes, excluding boarding care homes.

Level I	
Service A	Service B
Home Management of IADLs <ul style="list-style-type: none"> Shopping House cleaning Meal preparation Laundry 	IADLs <ul style="list-style-type: none"> Medication setup, cuing and reminding (supervision only)
	ADLs-attendant supervises the customer <ul style="list-style-type: none"> Bathing Grooming Dressing Toileting Transferring Walking/Mobility Eating Accompanying to obtain necessary medical services

ENROLLMENT:

For Service A only -

- Non-medical resident care facilities licensed by SRS.
- Entities not licensed by SRS, KDOA or KDHE must provide the following:
 - a certified copy of its Articles of Incorporation or Articles of Organization. If a Corporation or Limited Liability Company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.
 - written proof of liability insurance or a surety bond

ATTENDANT CARE SERVICES – PROVIDER DIRECTED (cont'd)

For Service A or B -

- County Health Departments
- The following entities licensed by KDHE:
 - Medicare Certified Home Health Agencies or State Licensed Home Health Agencies
 - The following entities licensed by KDOA:
 - Boarding Care Homes

REIMBURSEMENT:

One Unit = Fifteen minutes

Maximum Unit Cost = Level I A or B = \$3.38

Procedure Code = S5130

Level II (An initial RN evaluation visit is necessary)

Service C	Service D
ADLs- physical assistance or total support <ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services 	Health Maintenance Activities <ul style="list-style-type: none"> • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance
	An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a Licensed Nurse.
	A certified Home Health Aide or Certified Nurse Aide shall not perform acts beyond the scope of their curriculum without delegation by a Licensed Nurse.

ATTENDANT CARE SERVICES – PROVIDER DIRECTED (cont'd)

Level III (An initial RN evaluation visit is necessary)

<p>ADLs- physical assistance or total support</p> <ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services 	<p>Health Maintenance Activities</p> <ul style="list-style-type: none"> • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Enteral nutrition • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance
<p>IADLs</p> <ul style="list-style-type: none"> • Shopping • House cleaning • Meal preparation • Laundry • Medication setup, cuing, and reminding 	<p>An attendant who is a certified Home Health Aide or a Certified Nurse Aide shall not perform any Health Maintenance Activities without delegation by a Licensed Nurse.</p>
	<p>A certified Home Health Aide or Certified Nurse Aide shall not perform acts beyond the scope of their curriculum without delegation by a Licensed Nurse.</p>

Medication Administration / Assistance in Licensed Facilities (K.A.R. 26-41-205 and K.A.R. 26-42-205):

1. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.
2. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications.
3. If a facility is responsible for the administration of a resident's medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.

Medication Administration / Assistance in a Private Residence (K.A.R. 28-51-108):

A KDHE Licensed or Medicare Certified Home Health Agency can provide nursing delegation to aides with sufficient training. The nurse delegation and training shall be specific to the particular customer and their health needs. The qualified nurse retains overall responsibility.

ATTENDANT CARE SERVICES – PROVIDER DIRECTED (cont'd)

ENROLLMENT:

For Level II Service C or D -

- County Health Departments
- The following entities licensed by KDHE:
 - Medicare Certified Home Health Agencies or State Licensed Home Health Agencies
 - The following entities licensed by KDOA:
 - Home Plus, Assisted Living Facilities, or Residential Health Care Facilities

For Level III Services

- The following entities licensed by KDOA:
- Home Pluses
- Assisted Living Facilities
- Residential Health Care Facilities

REIMBURSEMENT:

One Unit = fifteen minutes

Maximum Unit Cost = Level II C or D = \$3.73

Procedure Code = S5125

Maximum Unit Cost = Level III = \$4.12

Procedure Code = S5125 UA

LIMITATIONS (LEVEL I AND II):

- Attendants must be 18 years or older.
- Covered ADL and IADL services are limited as defined within the CSW and approved Plan of Care.
- Attendant care is limited to a maximum of twelve (12) hours per day of any combination of provider-directed Level I, provider-directed level II, and self-directed.
- Attendant care is limited to a maximum of twelve (12) hours per day of provider-directed Level III.
- Transportation is not covered with this service, but if medically necessary, it may be covered through regular Medicaid.
- A customer's spouse, guardian, conservator, person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a customer shall not be paid to provide Attendant Care for the customer. The only exception to this policy will be a relative who is an employee of an assisted living facility, residential health care facility, or home plus in which the customer resides and the relative's relationship is within the second degree of the customer. (See KAR 26-41-101 and KAR 26-42-101 for regulatory requirements.)
- This service shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.
- More than one attendant will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and the case log by the case manager for a two-person lift or transfer.

ATTENDANT CARE SERVICES - SELF-DIRECTED

Attendant care services provide supervision and/or physical assistance with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs) for individuals who are unable to perform one or more activities independently. (K.S.A. 65-6201) Attendant care services may be provided in the individual's choice of housing, including temporary arrangements. This service shall not duplicate other waiver services.

IADLs	ADLs
<ul style="list-style-type: none"> • Shopping • House cleaning • Meal preparation • Laundry • Medication set up, cueing or reminding, and treatments • Life management (financial matters, i.e., bill paying) 	<ul style="list-style-type: none"> • Bathing • Grooming • Dressing • Toileting • Transferring • Walking/Mobility • Eating • Accompanying to obtain necessary medical services
HEALTH MAINTENANCE ACTIVITIES	
<ul style="list-style-type: none"> • Monitoring vital signs • Supervision and/or training of nursing procedures • Ostomy care • Catheter care • Entrhral nutrition 	<ul style="list-style-type: none"> • Wound care • Range of motion • Reporting changes in functions or condition • Medication administration and assistance

Customers or their representatives are given the option to self-direct their attendant care services. The customer's representative may be an individual acting on behalf of the customer, an activated durable power of attorney for health care decisions, or a guardian and/or conservator. If the customer or representative chooses to self-direct attendant care, he or she is responsible for making choices about attendant care services, including the referring for hire, supervising, and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices. Self-directed attendant care is subject to the same quality assurance standards as other attendant care providers including, but not limited to, completion of the tasks identified on the customer service worksheet.

According to K.S.A. 65-1124(l), a customer who chooses to self-direct their care is not required to have their attendant care supervised by a nurse. Furthermore, K.S.A. 65-6201(d) states that Health Maintenance Activities can be provided "... if such activities in the opinion of the attending physician or licensed professional nurse may be performed by the individual if the individual were physically capable, and the procedure may be safely performed in the home." Health Maintenance Activities and medication set up must be authorized, in writing, by a physician or licensed professional nurse.

ENROLLMENT:

Providers must meet the provider requirements for Financial Management Services (FMS). Direct support workers must be referred to the enrolled FMS provider of the customer's choice for completion of required human resources and payroll documentation.

REIMBURSEMENT:

One Unit = fifteen minutes

Maximum Unit Cost= \$2.71

Procedure Code with Modifier = S5125 UD

ATTENDANT CARE SERVICES - SELF-DIRECTED (cont'd)

LIMITATIONS:

- Direct support workers must be 18 years of age or older.
- A customer who has a guardian and/or conservator cannot choose to self-direct his or her attendant care; however, a guardian and/or conservator can make that choice on the ward's behalf.
- A guardian, a conservator, a person authorized as an activated Durable Power of Attorney (DPOA) for health care decisions, or an individual acting on behalf of a customer cannot choose himself/herself as the paid direct support worker. If the designation of the appointed representative is withdrawn, the individual may become the customer's paid direct support worker after the next annual review or a significant change in the customer's needs occurs prompting a reassessment.

EXCEPTION TO THIS LIMITATION: Customers who were active on any HCBS waiver prior to July 1, 2000, and have had the same representative continually directing their care during that time, are exempt from this limitation. The TCM shall complete a home visit at least every three months to ensure that the selected direct support worker is performing the necessary services.

- While a family member may be paid to provide attendant care, a customer's spouse shall not be paid to provide attendant care services unless one of the following criteria from K.A.R. 30-5-307 are met and prior approval received from the KDOA TCM program manager:
 1. Three HCBS provider agencies furnish written documentation that the customer's residence is so remote or rural that HCBS services are otherwise completely unavailable;
 2. Two health care professionals, including the attending physician, furnish written documentation that the customer's health, safety, or social well-being, would be jeopardized; (Note- documentation must contain how or in what way the customer's health, well-being, safety, or social well-being would be jeopardized);
 3. The attending physician furnishes written documentation that, due to the advancement of chronic disease, the customer's means of communication can be understood only by the spouse; or
 4. Three HCBS providers furnish written documentation that delivery of HCBS services to the customer poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable.
- The TCM and the customer or his or her representative will use discretion in determining if the selected direct support worker can perform the needed services.
- Covered ADL and IADL services are limited as defined within the CSW and approved Plan of Care.
- Attendant care services are limited to a maximum of twelve (12) hours per day of any combination of provider-directed Level I, provider-directed level II, and self-directed.
- Transportation is not covered with this service, but if medically necessary, it may be covered through regular Medicaid.
- This service shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.
- More than one direct support worker will not be paid for services at any given time of the day; the only exception is when justification is documented on the Customer Service Worksheet and case log by the case manager for a two person lift or transfer.
- Customers residing in ALFs, RHCs, Boarding Care Homes or Home Plus have chosen that provider as their selected caregiver. These housing choices supersede the self-directed care choice.

COMPREHENSIVE SUPPORT

DEFINITION:

Comprehensive Support is one-on-one non-medical assistance, observation, and supervision, provided to a cognitively impaired adult to meet their health and welfare needs. The provision of comprehensive support does not entail hands-on nursing care. The primary focus is supportive supervision.

The support worker is present to supervise the customer and to assist with incidental care as needed, as opposed to attendant care which is task specific. Leisure activities (for example, reading mail, books and magazines or writing letters) may also be provided.

Comprehensive Support may be provided in the customer's choice of housing, including temporary arrangements.

There are two methods of providing Comprehensive Support, provider directed and self-directed. Customers are given the option to self-direct their Comprehensive Support. A combination of service providers, either provider directed and/or self-directed, may be used to meet the approved Plan of Care.

The customer's representative is given the option to self-direct the customer's comprehensive support. He or she may be an individual acting on behalf of the participant, a person authorized as an activated Durable Power of Attorney for health care decisions, or a guardian, or a conservator. If the representative chooses to self-direct comprehensive support, he or she is responsible for making choices about comprehensive support, including the referring for hire, supervising and terminating the employment of support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

LIMITATIONS:

- Comprehensive Support is limited to the customer's assessed level of service need, as specified in the customer's POC, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.
- Support workers must be 18 years of age or older.
- Comprehensive support is limited to a maximum of 48 units (12 hours) per day to occur during the customer's normal waking hours. Comprehensive support in combination with other FE waiver services cannot exceed 24 hours per day.
- A customer who has a guardian and/or conservator cannot choose to self-direct his or her comprehensive support; however, a guardian and/or conservator can make that choice on the ward's behalf.
- Under no circumstances shall a customer's spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a customer be paid to provide Comprehensive Support for the customer.
- For those customers self-directing, the Targeted Case Manager and the customer or their representative will use discretion in determining if the selected support worker can perform the needed services.
- Customers residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care Home must have this service provided by a licensed home health agency and are not eligible to self-direct this service.
- An individual providing Comprehensive support must have a permanent residence separate and apart from the customer.

COMPREHENSIVE SUPPORT (cont'd)

- This service is limited to those customers who live alone or do not have a regular caretaker for extended periods of time.
- Comprehensive support cannot be provided at the same time as HCBS/FE Attendant Care Services or HCBS/FE Sleep Cycle Support.
- This service shall not be paid while the participant is hospitalized, in a nursing home, or other situation when the participant is not available to receive the service.

ENROLLMENT:

Provider-Directed:

Medicare-certified or KDHE-licensed Home Health Agencies (HHA); Centers for Independent Living (CIL); County Health Departments; and Entities not licensed by SRS, KDOA, or KDHE.
Entities not licensed by SRS, KDOA, or KDHE must provide the following documentation:

A certified copy of its Articles of Incorporation or Articles of Organization. If a Corporation or Limited Liability Company is organized in a jurisdiction outside the state of Kansas, the entity shall provide written proof that it is authorized to do business in the state of Kansas.

Written proof of liability insurance or surety bond

Self-Directed:

Providers must meet the provider requirements for Financial Management Services (FMS). Direct support workers must be referred to the enrolled FMS provider of the customer's choice for completion of required human resources and payroll documentation.

REIMBURSEMENT:

One Unit = 15 minutes

Unit cost – provider-directed rate = \$3.38

Procedure code = S5135

Unit cost – self-directed rate = \$2.71

Procedure code = S5135UD

FINANCIAL MANAGEMENT SERVICES

DEFINITION:

Financial Management Services (FMS) is provided for customers who are aging or disabled and will be provided within the scope of the Agency with Choice (AWC) model. Within the self-directed model and Kansas state law (K.S.A. 39-7,100), customers have the right to “make decisions about, direct the provisions of and control the attendant care services received by such individuals including, but not limited to selecting, training, managing, paying and dismissing a direct support worker.” The customer or customer’s representative has decision-making authority over certain services and takes direct responsibility to manage these services with the assistance of a system of available supports. FMS is included in these supports.

The AWC FMS is the employer-option model Kansas has available to customers who reside in their own private residence or the private home of a family member and have chosen to self-direct some or all of their services. The customer or his or her representative has the right to choose this employer-option model and the right to choose from qualified available FMS providers. This information must be made available at the time of making the choice to self-direct services and annually thereafter. The FMS provider must be listed on the POC and the administrative functions of the FMS provider are reimbursed as a waiver service.

When a customer or customer’s representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:

- Choose and direct support services
- Choose and direct the workers who provide the services
- Perform the roles and responsibilities as employer
- Understand the roles and responsibilities of the FMS provider
- Receive initial and ongoing skills training as requested.

Once fully informed, the customer or customer’s representative must negotiate, review, and sign an FMS Service Agreement developed and made available by the State of Kansas and distributed by the FMS provider. The FMS Service Agreement will identify the “negotiated” role and responsibilities of both the customer and the FMS provider. It will specify the responsibilities of each party.

Information and Assistance has been incorporated into the definition and requirements of the FMS provider:

- Information and Assistance (I&A) is a service available to provide information, including independent resources, and assistance in the development of options to ensure customers understand the responsibilities involved with directing their services. Practical skills training is offered to enable self-directing customers, their families, and/or representatives to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring direct support workers, managing workers, effectively communicating, and problem-solving. The extent of the assistance furnished to the self-directing customer will be determined by the self-directing customer or customer’s representative.
- I&A services may include activities that nominally overlap with the provision of information concerning self-direction provided by a case manager. However, this overlap does not allow the FMS provider to be involved in the development of the CSW and/or other planning documents or assessments.

FINANCIAL MANAGEMENT SERVICES (cont'd):

- I&A services may provide assistance to the self-directed customer or customer's representative with:
 - Defining goals, needs, and resources
 - Identifying and accessing services, supports, and resources as they pertain to self-directed activities
 - Learning practical management skills training (such as hiring, managing, and terminating workers; problem solving; conflict resolution)
 - Recognizing and reporting critical events (such as fraudulent activities, abuse)
 - Managing services and supports
- I&A services may provide information to the self-directing customer or customer's representative about:
 - Individual-centered planning
 - Range and scope of customer's choices and options
 - Grievance and appeals processes
 - Risks and responsibilities of self-direction
 - Individual rights
 - Importance of ensuring direct support worker's (DSW) health and safety during the course of his or her duties to reduce potential injuries and worker's compensation insurance claims
 - *Note:* This may include participation in training as directed by the self-directing customer.
 - Reassessment and review schedules
 - Importance of keeping the FMS provider agency and TCM informed with current contact information and planned absences
 - Other subjects pertinent to the customer and/or family in managing and directing services and living independently and safely in the community in the most integrated setting
- The Kansas "Self-Direction Tool Kit" is recommended as a resource for I&A.
- The I&A services a customer chooses to access must be outlined in a service agreement that identifies what support a self-directing customer may want or need.

LIMITATIONS:

- The customer or customer's representative cannot receive payment for the administrative functions he or she may perform.
- Only one FMS provider is to be authorized on a POC per month.
- Access to this service is limited to customers or their representatives who direct some or all of their services.

FINANCIAL MANAGEMENT SERVICES (cont'd):

ENROLLMENT:

Each potential Agency with Choice Financial Management Services (FMS) entity must meet the following requirements:

1. SRS/KDOA Provider Agreement
 - a. Applications are available on the following website:
<http://www.srs.ks.gov/agency/css/Pages/default.aspx> or www.aging.ks.gov.
 - b. The application must be completed and returned as identified on the website.
 - c. Application must be complete. Incomplete applications or the failure to provide required documentation will result in the application being pended awaiting completed documentation.
 - d. SRS/KDOA Provider Agreements are valid for three (3) years unless revoked, withdrawn or surrendered.
2. Medicaid Provider Agreement
 - a. Medicaid Provider Agreement cannot be obtained without the presentation of a valid, approved SRS/KDOA provider agreement.
 - b. Medicaid provider requirements can be located at: <https://www.kmap-state-ks.us>.
3. Registration with the Secretary of State's office, if required, including the following:
 - a. Be in good standing with all Kansas laws/business requirements.
 - b. Owners/Principles/Administrators/Operators have no convictions of embezzlement, felony theft, or fraud.
 - c. Owner, primary operator and administrator of FMS business must live in a separate household from individuals receiving services from the FMS business.
 - d. Business is established to provide FMS to more than one individual.
4. Insurance defined as:
 - a. Liability insurance with a \$500,000 annual minimum
 - b. Workers Compensation Insurance
 - i. Policy that covers all workers
 - ii. Meets all requirements of the State of Kansas
 - iii. Demonstrates the associated premiums are paid in a manner that ensures continuous coverage
 - c. Unemployment insurance (if applicable)
 - d. Other insurances (if applicable)
5. Annual Independent Financial Audit
6. Demonstrate financial solvency
 - a. Evidence that 30 days coverage of operation costs are met (cash requirements will be estimated utilizing the past quarter's performance from the date of review or if a new entity, provider must estimate the number of individuals that they reasonably expect to serve utilizing nominal costs).
 - b. Evidence may include the following:
 - a. Cash (last three bank statements)
 - b. Open line of credit (statement(s) from bank/lending institution)
 - c. Other (explain)

FINANCIAL MANAGEMENT SERVICES (cont'd):

7. Maintain required policies/procedures including, but not limited to;
 - a. Policies/procedures for billing Medicaid, in accordance with approved rates, for services authorized by Plan of Care (POC).
 - b. Policies/procedures for billing FMS administrative fees
 - c. Policies/procedures to receive and disburse Medicaid funds, track disbursements and provide reports
 - i. Semi-annual reports to self-direct individuals for billing/disbursements on their behalf
 - ii. Report to the State of Kansas, as requested
 - d. Policies/procedures that ensure proper/appropriate background checks are conducted on all individuals (FMS provider and DSW) in accordance with program requirements
 - e. Policies/procedures that ensure that self-directing individuals follow the pay rate procedures established by the State of Kansas when setting DSW's pay rates.
 - i. Clear identification of how this will occur
 - ii. Prohibition of wage/benefit setting by FMS provider
 - iii. Prohibition of "recruitment" of self-direct individuals (HCBS waiver consumers/participants and/or DSW staff) by enticements/promises of greater wages and/or benefits through the improper use of Medicaid funds.
 - f. Policies/procedures that ensure proper/appropriate process of timesheets, disbursement of pay checks, filing of taxes and other associated responsibilities
 - g. Policies/procedures regarding the provision of Information & Assistance services
 - h. Policies/procedures for Grievance. The Grievance Policy is designed to assure a method that DSWs can utilize to address hours paid that differ from hours worked, lack of timely pay checks, bounced pay checks, and other FMS-related issues.

REIMBURSEMENT:

One unit = one month

Unit Cost = \$115.00

Procedure Code = T2040 U2

HOME TELEHEALTH

DEFINITION:

Home telehealth is a remote monitoring system provided to a customer that enables the customer to effectively manage one or more diseases and catch early signs of trouble so intervention can occur before the customer's health declines. The provision of home telehealth entails customer education specific to one or more diseases, counseling, and nursing supervision.

Home telehealth automates disease management activities, and engages customers with personalized daily interactions and education to build or expand the customer's self-management behaviors. The service will enable telehealth providers, after determining the customer's progress, to motivate behavior changes through user-friendly technology, helping customers meet goals for improved compliance with diet, exercise, medication, medical treatments, and self-monitoring of conditions to lower healthcare costs.

The provider will access the telehealth system to review each customer's baseline, defined by the customer's physician at enrollment, trended survey responses, and vital sign measurements. A licensed nurse will monitor the health status of multiple customers, and is alerted if vital parameters or survey responses indicate a need for follow-up by a health care professional.

Customers qualify for this service if the customer:

is in need of disease management consultation and education; and

has had two or more hospitalizations, including ER visits, within the previous year related to one or more diseases; or

is using Money Follows the Person to move from a nursing facility back into the community.

The provider must train the customer and caregiver on use of the equipment. The provider must also ensure ongoing customer education specific to one or more diseases, counseling, and nursing supervision. Customer education shall include such topics as learning symptoms to report, the disease process, risk factors, and other relevant aspects relating to the disease.

HCBS/FE home telehealth services is not a duplication of Medicare telehealth services. While the Kansas legislature calls this service home telehealth, the actual service follows the CMS telemonitoring definition which Medicare does not cover. HCBS/FE home telehealth is a daily monitoring of the customer's vital sign measurements from the customer's home setting to prevent a crisis episode; whereas Medicare telehealth includes specific planned contacts for professional consultations, office visits, and office psychiatry services, usually through video contact.

During KDOA's plan of care approval process, KDOA will confirm there is no prior authorization for Medicaid home telehealth skilled nursing visits in the Medicaid Management Information System (MMIS). If a prior authorization is identified, HCBS/FE home telehealth services will be denied.

HOME TELEHEALTH (cont'd):

LIMITATIONS:

- Registered Nurse (RN) or licensed practical nurse with RN supervision to set up/ supervise/provide customer counseling.
- Customer must have a landline or wireless connection.
- Installation required within 10 working days of approval.
- Maximum of two installations per calendar year.
- Monthly status reports to the physician and case manager.
- Minimum monthly customer contact to reinforce positive self-management behaviors.
- If customer fails to perform daily monitoring for seven (7) consecutive days, case manager must be notified to determine if continuation of the service is appropriate.
- Customers living in an Assisted Living Facility, Residential Health Care Facility, or a Home Plus are not eligible for this service.

ENROLLMENT:

County Health Departments

The following entities licensed by KDHE:

Medicare Certified Home Health Agencies

State Licensed Home Health Agencies

REIMBURSEMENT:

Rental:

One unit = one day

Unit Cost = \$6.00

Procedure code = S0317

Install:

One unit = installation (maximum of two installations per calendar year)

Maximum cost = \$70.00

Procedure code = S0315

MEDICATION REMINDER

DEFINITION:

A Medication Reminder System provides a scheduled reminder to a customer when it's time for him/her to take medications. The reminder may be a phone call, an automated recording or an automated alarm, depending on the provider's system.

This service does not duplicate other waiver services.

LIMITATIONS:

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/Replacement of rental equipment is not covered.
- Rental, but not purchase, of this service is covered.
- This service is limited to those customers who live alone, or who are alone a significant portion of the day and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
- These systems may be maintained on a monthly rental basis even if a customer is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.
- This service is available in the customer's place of residence, excluding adult care homes.

ENROLLMENT:

Any company providing medication reminder services is eligible to enroll. Adult Care Homes are excluded from this service.

REIMBURSEMENT:

One unit = one month

Unit Cost = \$15.91

Procedure Code = S5185

NURSING EVALUATION VISIT

DEFINITION:

A Nursing Evaluation Visit is different from the initial assessment that is used to develop the Plan of Care. Nursing Evaluation Visit is a service provided only to customers that receive Level II Attendant Care Services through a Home Health Agency, Assisted Living Facility, Residential Health Care Facility, or other licensed entity. Nursing Evaluation Visits are conducted by a RN employed by the provider of Level II Attendant Care Services. During the Nursing Evaluation Visit, the RN determines which attendant may best meet the needs of the customer, and any special instructions/requests of the customer regarding delivery of services.

This service includes an initial face-to-face evaluation visit by an RN, one time, per customer, per provider.

LIMITATIONS:

- A Nursing Evaluation Visit will need to be completed for a customer who needs provider-directed Attendant Care Services Level II.
- If a customer chooses a home health agency that has provided nursing services to the customer in the past and the agency is already familiar with the customer's health status, a Nursing Evaluation Visit is not required.
- This service must be provided by a RN employed by, or a self-employed RN contracted by, the Attendant Care Level II provider.
- A Nursing Evaluation Visit is not conducted when a customer chooses to self-direct Attendant Care Services (see the Attendant Care Scope of Services Statement).
- The RN is responsible for submitting a written report to the targeted case manager within two weeks of the visit. This report will include any observations or recommendations the nurse may have relative to the customer which were identified during the Nursing Evaluation Visit.

ENROLLMENT:

- County Health Departments
- Self-Employed Registered Nurses licensed in Kansas
- The following entities licensed by KDHE:
 - Medicare Certified Home Health Agencies
 - State Licensed Home Health Agencies
- The following entities licensed by KDOA:
 - Home Plus
 - Assisted Living Facilities
 - Residential Health Care Facilities

REIMBURSEMENT:

One Unit = One face-to-face visit

Unit cost = \$39.37

Procedure Code = T1001

ORAL HEALTH SERVICES

DEFINITION:

Oral Health Services shall mean accepted dental procedures, to include diagnostic, prophylactic, and restorative care, and allow for the purchase, adjustment, and repair of dentures, which are provided to adults (age 65 and older) who are enrolled in the HCBS/FE waiver. Anesthesia services provided in the dentist's office and billed by the dentist shall be included within the definition of Oral Health Services.

LIMITATIONS:

- Oral Health Services are limited to the customer's assessed level of service need, as specified in the customer's POC, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception in accordance with the established KDOA policies and guidelines.
- To avoid duplication of services, Oral Health Services only include needed services not covered by regular State Plan Medicaid, and are limited to those services which cannot be procured from other formal or informal resources such as community donations received by the case management entity (CME) to use toward oral health services, other formal programs funded from state general funds, and Medicare 65 plans.
- Services shall not include outpatient or inpatient facility care.
- Orthodontic and implant services are not covered.
- Complete or partial dentures are allowed once every 60 months.
- Provision of Oral Health Services for cosmetic purposes is not a covered service.

ENROLLMENT:

Dentists and dental hygienists licensed to practice in the state of Kansas are eligible to enroll.

PERSONAL EMERGENCY RESPONSE

DEFINITION:

Diagnosis alone does not determine need for this service. The targeted case manager authorizes the need for this service based on an underlying medical or functional impairment.

This service does not duplicate other waiver services.

Personal emergency response units are electronic devices and have portable buttons worn by the customer. These units provide 24-hour-a-day on-call support to the customer having a medical or emergency need that could become critical at any time.

Examples include:

- Potential for Injury
- Cardiovascular Condition
- Diabetes
- Convulsive Disorders
- Neurological Disorders
- Respiratory Disorders

LIMITATIONS:

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/Replacement of rental equipment is not covered.
- Rental, but not purchase, of this service is covered.
- Call lights do not meet this definition.
- This service is limited to those customers who live alone, or who are alone a significant portion of the day in residential settings, and have no regular caretaker for extended periods of time, and who otherwise require extensive routine supervision.
- Once installed, these systems may be maintained on a monthly rental basis even if the customer is admitted to a nursing facility or acute care facility for a planned brief stay period not to exceed the two months following the month of admission in accordance with public assistance policy.
- Installation for each customer is limited to twice per calendar year.

ENROLLMENT:

Any company providing personal emergency response systems is eligible to enroll.

REIMBURSEMENT:

Rental:

One unit = one month

Unit Cost = \$26.52

Procedure code = S5161

Install:

One unit = installation (maximum of two installations per calendar year)

Maximum cost = \$56.25

Procedure code = S5160

SLEEP CYCLE SUPPORT

DEFINITION:

This service provides non-nursing physical assistance and/or supervision during the customer's normal sleeping hours in the customer's place of residence, excluding adult care homes. This service includes physical assistance or supervision with toileting, transferring and mobility, and prompting and reminding of medication. This service shall not duplicate other waiver services.

Direct support worker may sleep but must awaken as needed to provide assistance as identified in the customer's service plan. Direct support worker must provide the customer a mechanism to gain their attention or awaken them at any time. Direct support worker must be ready to call a physician, hospital or other medical personnel should an emergency arise. Support worker must submit a report to the TCM within the first business day following any emergency response provided the customer.

Sleep Cycle Support is a self-directed service. The customer or representative is responsible for making choices about sleep cycle support, including the referring for hire, supervising and terminating the employment of direct support workers; understanding the impact of those choices; and assuming responsibility for the results of those choices.

LIMITATIONS:

- Sleep Cycle Support is limited to the customer's assessed level of service need, as specified in the customer's POC, not to exceed twelve (12) hours per 24-hour time period, subject to an exception process established by the state. All customers are held to the same criteria when qualifying for an exception, in accordance with the established KDOA policies and guidelines.
- Direct support workers must be 18 years of age or older.
- Period of service must be at least six hours in length but cannot exceed a twelve hour period of time.
- Only one unit is allowed within a 24-hour period of time.
- Sleep cycle support in combination with other HCBS/FE waiver services cannot exceed 24 hour per day.
- Under no circumstances shall a customer's spouse, guardian, conservator, person authorized as an activated DPOA for health care decisions, or an individual acting on behalf of a customer be paid to provide Sleep Cycle Support for the customer.
- Customers residing in an Assisted Living Facility, Residential Health Care Facility, Home Plus, or Boarding Care Home are not eligible for this service.
- The direct support worker must have a permanent residence separate and apart from the customer.
- The targeted case manager and the customer or his or her representative will use discretion in determining if the selected direct support worker can perform the needed service.
- This service shall not be paid while the customer is hospitalized, in a nursing home, or other situation when the customer is not available to receive the service.

ENROLLMENT:

Providers must meet the provider requirements for Financial Management Services (FMS). Direct support workers must be referred to the enrolled FMS provider of the customer's choice for completion of required human resources and payroll documentation.

REIMBURSEMENT:

One unit = Six to Twelve Hours
Unit Cost = \$22.44
Procedure code = T2025

WELLNESS MONITORING

DEFINITION:

This service provides a Wellness Monitoring visit through nursing assessment by a licensed nurse. This service provides an opportunity for the nurse to check a customer's health concerns that have been identified by the targeted case manager. This service reduces the need for routine physician/health professional visits and care in more costly settings. Any changes in the health status of the customer during the visits are then brought to the attention of the targeted case manager and the physician as needed. A written report must be sent to the targeted case manager documenting the customer's status within two (2) weeks of the nurse visit.

This service includes:

- Nursing diagnosis
- Nursing treatment
- Counseling and health teaching
- Administration/supervision of nursing process
- Teaching of the nursing process
- Execution of the medical regimen

LIMITATIONS:

- Wellness Monitoring is limited to one face-to-face visit every 55 days, or less frequently, as determined by the targeted case manager.
- Wellness Monitoring requires a written follow-up report within two weeks of the face-to-face visit by the licensed nurse. This report will be sent to the targeted case manager regarding the findings and recommendation of the licensed nurse.
- When a LPN performs this service, the provider must ensure that the requirements of the Nurse Practice Act are met.

ENROLLMENT:

- County Health Departments
- The following entities licensed by KDHE:
 - Medicare Certified Home Health Agencies
 - State Licensed Home Health Agencies
- The following entities licensed by KDOA:
 - Home Plus
 - Assisted Living Facilities
 - Residential Health Care Facilities
- Self-employed Registered Nurses licensed in Kansas.

REIMBURSEMENT:

One Unit = One face-to-face visit

Unit Cost = \$39.37

Procedure Code = S5190

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Section 5: HCBS/FE Forms

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Prior to opening a case or changing services, the customer's TCM must send the following forms to the customer and provider(s):

Customer Service Worksheet (SS-009) – This worksheet details the specific tasks to be provided to the customer, i.e., assistance with bathing three times each week, grocery shopping once a week, laundry once a week and meal preparation two times each day. The provider will only receive this when there is attendant care services authorized.

- The CSW may give detailed times of the day or week when tasks are to be completed, or it may state that the tasks can be completed at times agreed upon by the customer and provider.
- If a task is not listed on the CSW, then it has not been approved to be provided to the customer.
- Attendants need to have copies of or review the CSW as they are to provide only the services recorded on the CSW.

Plan of Care (SS-005) (FSM 3.5.5)– This document is a paper form of the POC, which is entered into the computer system for prior authorization. The POC includes maximum dollar amounts authorized per service for the customer. It also includes other service information set forth in the Notice of Action. The customer will sign the POC but immediate changes may be made with the signature being obtained at the next home visit with the customer.

PLEASE NOTE: The POC is **not** to be used as a billing tool. POCs are figured on a 31-day or 5-week month.

- There are only 7 months with 31 days, and there are no months with 5 weeks.
- If the dollar amounts on the POC are billed on a monthly basis, this will ultimately result in an overpayment and recoupment.
- Providers must **ONLY** bill for the services that are documented as rendered in accordance with the Notice of Action, Customer Service Worksheet and Kansas Medical Assistance Program Provider Manual.

Although for billing purposes the system POC is authorized on a monthly basis, the total hours for a beneficiary cannot exceed the daily or weekly approved amount as specified in the Customer Service Worksheet, if applicable, written POC, and Notice of Action.

Notice of Action (KDOA 904)(FSM 1.3) – This document sets forth the services authorized to be provided. Included are:

- the number of units authorized,
- the date the service is to begin or end,
- the unit rate the provider may charge for the service,
- any client obligation the customer must pay, and
- any other instructions the Targeted Case Manager has regarding the customer's services.

In addition, the customers should receive a copy of their rights and responsibilities with the NOA.

A Notice of Action must be received prior to any changes occurring on the customer's case (FSM 1.3.2), i.e., change in units of service needed, change in client obligation, change in Case Manager, etc. If the change results in any adverse action to the customer, such as reduction of hours or case closure, ten (10) days notice must be given before the change is made to allow for the customer the opportunity to appeal the action.

Providers will receive the following:

- At initial opening and reassessments – the CSW (if receives attendant care services), the POC, and NOA.
- Each time there are changes or additions - the CSW (if receives attendant care services), the POC, and NOA.

KANSAS DEPARTMENT ON AGING – CUSTOMER SERVICE WORKSHEET

Date: 9/12/12

Customer Name: Maggie Smith		Address: Hometowne Alf		City: Anywhere		Zip: 60006	
County: JA		Phone #: 785-547-7485		DOB: HIPAA		Billing ID#: HIPAA	
Emergency Contact: Jennifer Nibbs		Relationship: Daughter		Phone #: 785-248-7149		Alt. Phone #: n/a	
Direct Support Worker Name: 		Relationship: 		Live with customer: Y / N		Phone #: 	
Direct Support Worker Name: 		Relationship: 		Live with customer: Y / N		Phone #: 	

UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: Hometowne ALF Service Code: ATCR3X	Provider: Service Code: 	Provider: Service Code: 	Informal / Non-KDOA Admin	Additional Time Request Information
3	Bathing/Grooming <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (oversight) (2) <input type="checkbox"/> Customer chooses lower level or N/A Specify: <input checked="" type="checkbox"/> Type: Bath / <input checked="" type="checkbox"/> Oral Hygiene/ <input checked="" type="checkbox"/> Hair Care/ <input type="checkbox"/> Skin Care/ <input type="checkbox"/> Shaving/ <input type="checkbox"/> Other Specify tasks being done: Assist in/out and with washing and drying.	30 min / twice per week = 60 minutes / week				ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
3	Dressing/Undressing <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A Prosthesis, specify: Specify what articles of clothing and tasks the customer is being assisted with: All articles and fastening.	10 min / twice per day = 140 minutes / week				ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
1	Toileting <input type="checkbox"/> Total Assist (4) <input type="checkbox"/> Physical Assist (includes pericare) (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input checked="" type="checkbox"/> Customer chooses lower level or N/A Special Needs: <input type="checkbox"/> Commode/ <input type="checkbox"/> Bedpan/ <input type="checkbox"/> Unal/ <input type="checkbox"/> Incontinence Mgmt/ <input type="checkbox"/> Ostomy (HMA)/ <input type="checkbox"/> Catheter Care (HMA)/ <input type="checkbox"/> Other 					ATR needed for this task: Y (N) If yes, date approved by KDOA: _____

KANSAS DEPARTMENT ON AGING – CUSTOMER SERVICE WORKSHEET

Customer Name: Maggie Smith				Date: 9/12/12		
UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: Hometowne ALF Service Code: ATCR3X	Provider: [redacted] Service Code: [redacted]	Provider: [redacted] Service Code: [redacted]	Informal / Non-KDOA Admin	Additional Time Request Information
trans 3	Mobility (includes transfer and walking) *Must identify where the customer is going within the home/residence* <input type="checkbox"/> Total Assist (bedfast) (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A	30 min / day = 210 minutes / week Assist as needed.				ATR needed for this task: Y / N If yes, date approved by KDOA: _____
walk 3	Assistive Device(s): <input type="checkbox"/> Wheelchair/ <input type="checkbox"/> Cane/ <input type="checkbox"/> Walker/ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Range of Motion (HMA)					
1	Eating <input type="checkbox"/> Total Assist (feed) (4) <input type="checkbox"/> Physical Assist (includes cutting food) (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input checked="" type="checkbox"/> Customer chooses lower level or N/A Special Nutrition: <input type="checkbox"/> Tube Feed (HMA)/ <input type="checkbox"/> Other _____					ATR needed for this task: Y / N If yes, date approved by KDOA: _____
4	Meal Preparation Specify: Breakfast/ Lunch/ Supper/ Snack <input checked="" type="checkbox"/> Total Assist: prepare and serve meal (4) <input type="checkbox"/> Physical Assistance w/ meal prep. (3) <input type="checkbox"/> Supervision (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A Specify: <input type="checkbox"/> Special Diet, type _____ <input type="checkbox"/> Future Meals/ <input checked="" type="checkbox"/> Lives in congregate/family setting.	All meals and snacks daily. 7 hours / week = 420 minutes / week.				ATR needed for this task: Y / N If yes, date approved by KDOA: _____
4	Shopping <input checked="" type="checkbox"/> Total Assist (unable to shop) (4) <input type="checkbox"/> Physical Assist (accompany) (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) *Informal only* <input type="checkbox"/> Customer chooses lower level or N/A Specify: <input type="checkbox"/> Groceries/ <input type="checkbox"/> Medication Pick-up/ <input type="checkbox"/> Hygiene/Medical Supplies				Family provides.	ATR needed for this task: Y / N If yes, date approved by KDOA: _____
3	Money Management (*Informal only*) <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (remind/oversight) (2) <input type="checkbox"/> Customer choose lower level or N/A	Informal	Informal	Informal	Family provides.	N/A

KANSAS DEPARTMENT ON AGING – CUSTOMER SERVICE WORKSHEET

Customer Name: Maggie Smith				Date: 9/12/12		
UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: Hometown ALF Service Code: ATCR3X	Provider: Service Code: 	Provider: Service Code: 	Informal / Non-KDOA Admin	Additional Time Request Information
3	Accompanying to Medical Appointments - specify the frequency <i>(* Other, such as: to shop and social activities is not covered *)</i> IADL Score for Transportation <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (2) <input type="checkbox"/> Customer chooses lower level or N/A				Family provides.	ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
1	Telephone Usage (*Informal only*)	<i>Informal</i>	<i>Informal</i>	<i>Informal</i>		N/A
3	Laundry/Housekeeping <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (2) <input type="checkbox"/> Customer chooses lower level or N/A Laundry Specify: <input type="checkbox"/> In home or apt. <input checked="" type="checkbox"/> In the apt. complex or facility <input type="checkbox"/> Outside home or apt. complex Cleaning (non-chore tasks) <input type="checkbox"/> Bathroom/ <input type="checkbox"/> Kitchen/ <input type="checkbox"/> Bedroom/ <input type="checkbox"/> Vacuum/ <input type="checkbox"/> Scrub Floors / <input type="checkbox"/> Commode/ <input type="checkbox"/> Change linens/ <input type="checkbox"/> Remove Trash/ <input type="checkbox"/> Dust/ <input type="checkbox"/> Other 	4 hours / week = 240 minutes / week				ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
3	Management of Medications/Treatments <input type="checkbox"/> Total Assist (w/ med. admin. & performing treatments, HMA) (4) <input checked="" type="checkbox"/> Physical Assist (w/ med. Admin. & performing treatments, HMA) (3) Supervise (2): Specify: <input type="checkbox"/> Oversight/Cueing <input type="checkbox"/> Medication Set-up <input type="checkbox"/> Customer chooses lower level or N/A <input type="checkbox"/> Other, specify: 	25 minutes / day = 175 minutes / week				ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
	Specify days and frequency:	Days: daily 83 Units Per week	Days: Units Per 	Days: Units Per 		1245 min/wk = 20.75 hr/ wk = 83 units/wk

☐ Check if more than one Customer Service Worksheet attached.

ATTENTION CUSTOMER: Your signature on your plan of care certifies that you were involved in the decision of which services you will receive, the tasks that will be provided as outlined on this customer service worksheet, and the amount of services to be provided.

UAI – Page 10 – Plan of Care/Support Services

Customer	Maggie Smith	Address	Hometowne ALF	Phone #	785-547-7485
Medicaid #	001000091234	KAMIS ID #		Other agency identifier	
Emergency Contact	Jennifer Nibbs	Relationship	Daughter	Phone: home	785-248-7149 work

[illegible]

Unmet Need Service Code, Availability Code, Monthly Number of Units						HCBS/FE monthly costs including customer obligation: (HCBS amount must be reported to EES Specialist) 1,749.17	
Service Code	Availability	Units	Service Code	Availability	Units	SCA total cost including customer copay:	
						Medicaid Average Acute Care Cost: 159.00	
						OAA total cost:	
						HCBS/FE Total Cost: \$1,908.17	
						Total customer obligation/copay: \$0	

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information included in these pages 1-10 will be released to Kansas Department on Aging and service providers listed above to enable the delivery of services and program monitoring.

<u>Maggie Smith</u> Customer or Guardian Signature	<u>9-12-12</u> Date	<u>Tobi Imacm 785-286-2222</u> Assessor Signature & Phone#
 Customer or Guardian Signature	 Date	 Assessor Signature & Phone#

Additional Support/Services from Home Health, Family, Friend, Neighbor, Attorney, Landlord, Church, Club, Other

[illegible]

KANSAS DEPARTMENT ON AGING

NOTICE OF ACTION

PROGRAM: ☐ Older Americans Act ☐ Senior Care Act ☒ HCBS/FE ☐ ESD

Date of Notice: 8/1/2011

TO:

Maggie Smith
Hometowne ALF
Anywhere, KS

FROM: Tobi Imacm

Agency:
SNEW CME

Attention:

Phone:

Medicaid # (if applicable): 001000091234

Billing #:

Service	No. of Units (Specify Per Day or Week)	Self Dir. Y/N ?	Provider Name	Dates of Service From To		Provider Unit Cost
Atcr2x	83/wk	N	Hometowne Alf	9/1/11		\$3.73
Mawmx	1/eom	N	Hometowne Alf	9/1/11		\$39.37
						\$
						\$
						\$
						\$

☐ Attached Customer Service Worksheet (check if applicable)

Client Obligation: \$

Paid To:

Comments, Message, or Explanation of Action:

☐ Effective , your services and/or plan of care are being implemented as identified above;☒ Or other:

Maggie,

Due to HCBS/FE policy changes to the Plan of Care development process and attendant care service limitations that are effective September 1, 2011 your Customer Service Worksheet has been reviewed and rewritten to be more specific in detailing your attendant care tasks.

These changes may affect current and future Plans of Care. This change is being implemented on a statewide basis and represents a State of Kansas Medicaid policy change.

Your services will continue without change and as indicated above.

cc: Hometowne ALF

Regulatory Reference(s): KDOA FSM 3.5.5.A-B, D

You may contact your case manager at the phone number above.

Please carefully read the Customer Rights and Responsibilities with this NOA (Note: not applicable for ESD).

Case Manager Signature: _____

Date: 8/1/2011

**KANSAS DEPARTMENT ON AGING
NOTICE OF ACTION**

PROGRAM: ☐ Older Americans Act ☐ Senior Care Act ☒ HCBS/FE ☐ ESD

Date of Notice: 10/25/12

TO: Maggie Smith Hometown ALF Anywhere, KS 	FROM: Tobi Imacm Agency SNEW CME
--	--

Attention: 	Phone: (785) 286-2222
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Medicaid # (if applicable): 001000091234	Billing #:
--	--

Service	No. of Units (Specify Per Day Or Week)	Self Dir. Y/N ?	Provider Name	Dates of Service From To		Provider Unit Cost
Attendant Care Level 3	83 units / wk	N	Hometowne Alf	11/1/12	Ongoing	\$4.12
Wellness Mont.	1 per 55 days	N	Hometowne Alf	11/1/12	Ongoing	\$39.37
						\$
						\$
						\$
						\$

☐ Attached Customer Service Worksheet (check if applicable)

Client Obligation: \$ None	Paid To:
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Comments, Message, or Explanation of Action:

☒ Effective 11/1/12, your services and/or plan of care are being implemented as identified above;
☐ Or other:

Dear Maggie,

Due to changes in your functional ability and needing additional assistance with medication management your HCBS/FE hours have been increased. Hometowne ALF will continue as your provider of Attendant Care Level III and Wellness Monitoring services. The increased hours will begin effective 11/1/2012 with 20.75 hours per week (83 units) of Attendant Care level III. Please contact me at the above number if you have any changes in your functional ability that may require a change to your services.

cc: Hometowne ALF, file

Regulatory Reference(s): KDOA FSM KDOA FSM 3.5.5

You may contact your case manager at the phone number above.

Please carefully read the Customer Rights and Responsibilities with this NOA (Note: not applicable for ESD).

Case Manager Signature: _____	Date: <u>10/25/12</u>
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KANSAS DEPARTMENT ON AGING – CUSTOMER SERVICE WORKSHEET

Date: 7/14/12

Customer Name: Morgan James		Address: 110 West Elm		City: Somewhere		Zip: 66666	
County: SN		Phone #: 785-469-5421		DOB: HIPAA		Billing ID#: HIPAA	
Emergency Contact: Jackson James		Relationship: Son		Phone #: 785-965-8742		Alt. Phone #: n/a	
Direct Support Worker Name: Abigail Leeper		Relationship: Neighbor		Live with customer: Y (N)		Phone #: 785-469-2168	
Direct Support Worker Name: 		Relationship: 		Live with customer: Y / N		Phone #: 	

UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: Home Health Service Code: ATCRUD	Provider: Somewhere Home Health Service Code: ATCR2X	Provider: Service Code: 	Informal / Non-KDOA Admin	Additional Time Request Information
3	Bathing/Grooming <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (oversight) (2) <input type="checkbox"/> Customer chooses lower level or N/A Specify: <input checked="" type="checkbox"/> Type: Shower / <input checked="" type="checkbox"/> Oral Hygiene/ <input type="checkbox"/> Hair Care/ <input type="checkbox"/> Skin Care/ <input checked="" type="checkbox"/> Shaving/ <input type="checkbox"/> Other Specify tasks being done: assist in/out of shower. Assist with washing and drying due to balance issues.	20 min / one day per week (Sunday) = 20 minutes / week	20 min / two days per week (Wednesday & Friday) 40 minutes / week			ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
3	Dressing/Undressing <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A Prosthesis, specify: Specify what articles of clothing and tasks the customer is being assisted with: all articles; fastening buttons.	15 min / twice per day = 210 minutes / week				ATR needed for this task: Y (N) If yes, date approved by KDOA: _____
3	Toileting <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (includes pericare) (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A Special Needs: <input checked="" type="checkbox"/> Commode/ <input type="checkbox"/> Bedpan/ <input type="checkbox"/> Urinal/ <input type="checkbox"/> Incontinence Mgmt/ <input type="checkbox"/> Ostomy (HMA)/ <input type="checkbox"/> Catheter Care (HMA)/ <input type="checkbox"/> Other 	also empty commode as necessary. 10 min / 4 times per day = 280 minutes / week				ATR needed for this task: Y (N) If yes, date approved by KDOA: _____

KANSAS DEPARTMENT ON AGING – CUSTOMER SERVICE WORKSHEET

Customer Name: <u>Morgan James</u>				Date: <u>7/14/12</u>		
UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: Home Health Service Code: <u>ATCRUD</u>	Provider: Somewhere Home Health Service Code: <u>ATCR2X</u>	Provider: <u> </u> Service Code: <u> </u>	Informal / Non-KDOA Admin	Additional Time Request Information
trans <u>2</u>	Mobility (includes transfer and walking) *Must identify where the customer is going within the home/residence* <input type="checkbox"/> Total Assist (bedfast) (4) <input type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A	<u> </u>	<u> </u>	<u> </u>	Jackson will provide supervision as needed.	ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
walk <u>2</u>	Assistive Device(s): <input type="checkbox"/> Wheelchair/ <input type="checkbox"/> Cane/ <input type="checkbox"/> Walker/ <input type="checkbox"/> Other (specify) <u> </u> <input type="checkbox"/> Range of Motion (HMA)					
<u>1</u>	Eating <input type="checkbox"/> Total Assist (feed) (4) <input type="checkbox"/> Physical Assist (includes cutting food) (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) <input checked="" type="checkbox"/> Customer chooses lower level or N/A Special Nutrition: <input type="checkbox"/> Tube Feed (HMA)/ <input type="checkbox"/> Other <u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
<u>3</u>	Meal Preparation Specify: Breakfast/ Lunch/ Supper/ Snack <input type="checkbox"/> Total Assist: prepare and serve meal (4) <input checked="" type="checkbox"/> Physical Assistance w/ meal prep. (3) <input type="checkbox"/> Supervision (oversight/cueing) (2) <input type="checkbox"/> Customer chooses lower level or N/A Specify: <input type="checkbox"/> Special Diet, type <u> </u> <input type="checkbox"/> Future Meals/ <input type="checkbox"/> Lives in congregate/ family setting.	prepare breakfast and supper Monday - Friday 4 hours / week = 240 minutes / week	<u> </u>	<u> </u>	Home delivered meals Monday - Friday. Jackson and Judy will provide meals on weekends.	ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
<u>3</u>	Shopping <input type="checkbox"/> Total Assist (unable to shop) (4) <input checked="" type="checkbox"/> Physical Assist (accompany) (3) <input type="checkbox"/> Supervise (oversight/cueing) (2) *Informal only* <input type="checkbox"/> Customer chooses lower level or N/A Specify: <input checked="" type="checkbox"/> Groceries/ <input type="checkbox"/> Medication Pick-up/ <input type="checkbox"/> Hygiene/Medical Supplies	1 hour / week = 60 minutes / week	<u> </u>	<u> </u>	<u> </u>	ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
<u>3</u>	Money Management (*Informal only*) <input type="checkbox"/> Total Assist (4) <input type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (remind/oversight) (2) <input type="checkbox"/> Customer choose lower level or N/A	Informal	Informal	Informal	Judy provides.	N/A

KANSAS DEPARTMENT ON AGING – CUSTOMER SERVICE WORKSHEET

Customer Name: <u>Morgan James</u>			Date: <u>7/14/12</u>			
UAI Code	Activities of Daily Living/ Instrumental Activities of Daily Living	Provider: <u>Home Health</u> Service Code: <u>ATCRUD</u>	Provider: <u>Somewhere</u> <u>Home Health</u> Service Code: <u>ATCR2X</u>	Provider: <u> </u> Service Code: <u> </u>	Informal / Non-KDOA Admin	Additional Time Request Information
3	Accompanying to Medical Appointments - specify the frequency <i>(*Other, such as: to shop and social activities is not covered*)</i> IADL Score for Transportation <input type="checkbox"/> Total Assist (4) <input checked="" type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (2) <input type="checkbox"/> Customer chooses lower level or N/A				<u>Jackson provides.</u>	ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
1	Telephone Usage (*Informal only*)	<i>Informal</i>	<i>Informal</i>	<i>Informal</i>		N/A
4	Laundry/Housekeeping <input checked="" type="checkbox"/> Total Assist (4) <input type="checkbox"/> Physical Assist (3) <input type="checkbox"/> Supervise (2) <input type="checkbox"/> Customer chooses lower level or N/A Laundry Specify: <input checked="" type="checkbox"/> In home or apt. <input type="checkbox"/> In the apt. complex or facility <input type="checkbox"/> Outside home or apt. complex Cleaning (non-chore tasks) <input checked="" type="checkbox"/> Bathroom/ <input checked="" type="checkbox"/> Kitchen/ <input type="checkbox"/> Bedroom/ <input checked="" type="checkbox"/> Vacuum/ <input type="checkbox"/> Scrub Floors / <input checked="" type="checkbox"/> Commode/ <input checked="" type="checkbox"/> Change linens/ <input checked="" type="checkbox"/> Remove Trash/ <input type="checkbox"/> Dust/ <input type="checkbox"/> Other <u> </u>	4 hours per week = <u>240 minutes / week</u>				ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
3	Management of Medications/Treatments <input type="checkbox"/> Total Assist (w/ med. admin. & performing treatments, HMA) (4) <input type="checkbox"/> Physical Assist (w/ med. Admin. & performing treatments, HMA) (3) Supervise (2): Specify: <input type="checkbox"/> Oversight/Cueing <input type="checkbox"/> Medication Set-up <input type="checkbox"/> Customer chooses lower level or N/A <input type="checkbox"/> Other, specify: <u> </u>	15 minutes / day = 1.75 hours per week = <u>105 minutes / week</u>				ATR needed for this task: Y <u>(N)</u> If yes, date approved by KDOA: _____
	Specify days and frequency:	Days: <u> </u> as specified <u>77</u> Units Per week	Days: <u> </u> as specified <u>3</u> Units Per week	Days: <u> </u> <u> </u> Units Per <u> </u>		1155 min/wk = 19.25 hrs/wk = 77 units/wk

☐ Check if more than one Customer Service Worksheet attached.

ATTENTION CUSTOMER: Your signature on your plan of care certifies that you were involved in the decision of which services you will receive, the tasks that will be provided as outlined on this customer service worksheet, and the amount of services to be provided.

Customer Morgan James Address 110WEIm Phone# 785-469-5421
 Medicaid# 000010806611 KAMIS ID # _____ Other agency identifier _____
 Emergency Contact Jackson James Relationship Son Phone: home 785-965-8742 work _____

AAA/CME	Service Code	Funding Source	Provider	Unit(s)	Per	Total Units Monthly	Start Date	End Date	Dis-charge Code	Cost of Unit	Customer Obligation/ Copay	Monthly Cost
13	ATCRUD	HCBS/FE	Home Health	77	Week	154	11-21-12	11-30-12	29	2.71	40.00	377.34
13	FMSSDX	HCBS/FE	Home Health	1	Month	1	11-21-12	11-30-12	29	115.00		115.00
13	ATCR2X	HCBS/FE	Somewhere Home Health	3	Week	6	11-21-12	11-30-12	29	3.73		22.38
13	NUEVX	HCBS/FE	Somewhere Home Health	1	Provider	1	11-21-12	11-30-12	14	39.37		39.37
										Sept =	594.09 + 159.00	= \$753.09
13	ATCRUD	HCBS/FE	Home Health	77	Week	385	12-1-12			2.71	75.00	968.35
13	FMSSDX	HCBS/FE	Home Health	1	Month	1	12-1-12			115.00		115.00
13	ATCR2X	HCBS/FE	Somewhere Home Health	3	Week	15	12-1-12			3.73		55.95
13	HMEL	OAA III C	MOW of Greater Kansas	5	Week	5	8-14-12	8-13-13		3.50		87.50
13	ASMT	TCM	SNEW CME	6	Year	6	8-14-12	8-14-12	14	10.83		64.98
13	CMGTS	TCM	SNEW CME	4	Month	4	8-14-12			10.83		

Unmet Need Service Code, Availability Code, Monthly Number of Units						HCBS/FE monthly costs including customer obligation: (HCBS amount must be reported to EES Specialist)		1214.30 +
Service Code	Availa- bility	Units	Service Code	Availa- bility	Units	SCA total cost including customer copay:		Medicaid Average Acute Care Cost: 159.00 =
						OAA total cost: \$87.50		HCBS/FE Total Cost: \$1,373.30
						Total customer obligation/copay: \$40 Nov / \$75 Dec		

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information included in these pages 1-10 will be released to Kansas Department on Aging and service providers listed above to enable the delivery of services and program monitoring.

Morgan's Signature 8/14/12 Christy's Signature 785-518-7846
 Customer or Guardian Signature Date Assessor Signature & Phone#
 Customer or Guardian Signature Date Assessor Signature & Phone#

Additional Support/Services from Home Health, Family, Friend, Neighbor, Attorney, Landlord, Church, Club, Other								
Name	Relationship (check if primary caregiver)	Address (indicate "same" if lives with customer)	Phone		Service	Frequency	Paid	
			Home	Work			Yes	No
Jackson James	Son	1999 Walnut	785-965-8742		CTKR	20 hours / month		X
Judy Smith	Daughter	100 Chicken Lane	785-227-3333		CTKR	10 hours / month		X

**KANSAS DEPARTMENT ON AGING
NOTICE OF ACTION**

PROGRAM: ☐ Older Americans Act ☐ Senior Care Act ☒ HCBS/FE ☐ ESD

Date of Notice: 11/15/2012						
TO: Morgan James 110 W. Elm Somewhere, KS 66666				FROM: Christy Smith Agency: SNEW CME 100 KDOA Lane Kansas, KS 66666 785-518-7846		
Attention: _____				Phone: _____		
Medicaid # (if applicable): 000010806611				Billing #: _____		
Service	No. of Units (Specify Per Day or Week)	Self Dir. Y/N ?	Provider Name	Dates of Service From To		Provider Unit Cost
Aterud	77/wk	Y	Home Health	11/21/12	_____	\$2.71
Fmssdx	1/mo	N	Home Health	11/21/12	_____	\$115.00
Ater2x	3/wk	N	Somewhere Home Health	11/21/12	_____	\$3.37
Nuevxx	once	N	Somewhere Home Health	11/21/12	11/30/12	\$39.37
_____	_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	_____	\$ _____
<input type="checkbox"/> Attached Customer Service Worksheet (check if applicable)						
Client Obligation: \$ 40/Nov \$75/Dec				Paid To: Home Health		
Comments, Message, or Explanation of Action:						
<input type="checkbox"/> Effective _____, your services and/or plan of care are being implemented as identified above; <input checked="" type="checkbox"/> Or other:						
Morgan, You have met the functional eligibility for HCBS/FE services. Please note your services listed above, on the attached customer service worksheet, and the plan of care. You have chosen to self-direct 19.25 hours per week (77 units) of your attendant care service hours, you selected Home Health as your Financial Management Services provider. You chose Somewhere Home Health to provide 40 minutes per week (3 units) of attendant care level II services and the one time nurse evaluation visit. You will also receive 5 meals per week (Monday - Friday) from Meals on Wheels of Greater Kansas.						
cc: Home Health; Somewhere Home Health						
Regulatory Reference(s): KDOAFSM3.5.5.A-B, D						
You may contact your case manager at the phone number above.						
Please carefully read the Customer Rights and Responsibilities with this NOA (Note: not applicable for ESD).						
Case Manager Signature: _____				Date: 11/15/2012		

KANSAS DEPARTMENT ON AGING
NOTICE OF ACTION

PROGRAM: ☐ Older Americans Act ☐ Senior Care Act ☒ HCBS/FE ☐ ESD

Date of Notice: 12/15/2012						
TO: Morgan James 110 W. Elm Somewhere, KS 66666			FROM: Christy Smith Agency: SNEW CME 100 KDOA Lane Kansas, KS 66666 785-518-7846			
Attention:			Phone:			
Medicaid # (if applicable): 000010806611			Billing #:			
Service	No. of Units (Specify Per Day or Week)	Self Dir. Y/N ?	Provider Name	Dates of Service From To		Provider Unit Cost
Aterud	77/wk	Y	Home Health			\$2.71
Fmssdx	1/mo	N	Home Health			\$115.00
						\$
						\$
						\$
						\$
<input type="checkbox"/> Attached Customer Service Worksheet (check if applicable)						
Client Obligation: \$ 86.50			Paid To: Home Health			
Comments, Message, or Explanation of Action:						
<input type="checkbox"/> Effective , your services and/or plan of care are being implemented as identified above; <input checked="" type="checkbox"/> Or other:						
Morgan, This notice is to inform you that your client obligation is changing to \$86.50 per month effective 1/1/13.						
cc: Home Health						
Regulatory Reference(s): KDOAFSM 3.5.5.A-B, D						
You may contact your case manager at the phone number above.						
Please carefully read the Customer Rights and Responsibilities with this NOA (Note: not applicable for ESD).						
Case Manager Signature: _____			Date: 12/15/2012			

KANSAS DEPARTMENT ON AGING
NOTICE OF ACTION

PROGRAM: ☐ Older Americans Act ☐ Senior Care Act ☒ HCBS/FE ☐ ESD

Date of Notice: 10/20/2013					
TO: Morgan James 110 W. Elm Somewhere, KS 66666			FROM: Christy Smith Agency: SNEW CME 100 KDOA Lane Kansas, KS 66666 785-518-7846		
Attention: _____			Phone: _____		
Medicaid # (if applicable): 000010806611			Billing #: _____		
Service	No. of Units (Specify Per Day or Week)	Self Dir. Y/N ?	Provider Name	Dates of Service From To	Provider Unit Cost
Atrud	77/wk	Y	Home Health	11/21/12	\$2.71
Fmssdx	1/mo	N	Home Health	11/21/12	\$115.00
Atr2x	3/wk	N	Somewhere Home Health	11/21/12	\$3.37
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
<input type="checkbox"/> Attached Customer Service Worksheet (check if applicable)					
Client Obligation: \$ 86.50			Paid To: Home Health		
Comments, Message, or Explanation of Action: <input type="checkbox"/> Effective _____, your services and/or plan of care are being implemented as identified above; <input checked="" type="checkbox"/> Or other: Morgan, You have been reassessed and found to continue to meet the functional eligibility for HCBS/FE services. There are no changes to your services at this time. Please note your services listed above, on the attached customer service worksheet, and the plan of care. You have chosen to self-direct 19.25 hours per week (77 units) of your attendant care service hours, you selected Home Health as your Financial Management Services provider. You chose Somewhere Home Health to provide 40 minutes per week (3 units) of attendant care level II services. You will also receive 5 meals per week (Monday - Friday) from Meals on Wheels of Greater Kansas.					
cc: Home Health; Somewhere Home Health Regulatory Reference(s): KDOAFSM3.5.5.A-B, D You may contact your case manager at the phone number above. Please carefully read the Customer Rights and Responsibilities with this NOA (Note: not applicable for ESD).					
Case Manager Signature: _____			Date: 10/20/2013		

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Section 6:

Reasons to contact the TCM

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- With any concerns regarding the customer, including health changes or welfare issues
- If the CSW or NOA isn't understandable or information conflicts, such as between dates or units
- Immediately upon knowledge of the customer going to the hospital, nursing facility, or being otherwise unavailable for services
- When services are not being provided as authorized, to the customer, due to staffing issues, customer choice to refuse and etc
- If the customer is falling behind in payments or refusing to pay his or her monthly client obligation
 - The provider determines the length of time allowed for non-payment before notifying the TCM and customer that service delivery will be stopped
- Refer any eligibility (HCBS/FE or Medicaid) issues or questions the customer may have to the TCM
- Any changes in the customer's hours (increase/decrease) or services must have prior approval by the TCM. The provider should not implement changes to the CSW tasks or POC as these services are based on identified needs.
 - If changes are needed, contact the TCM so a new CSW, POC, and NOA may be completed indicating the necessary changes
- Providers please remember:
 - Adverse actions, such as reduction in hours or closing the case, require 10 (ten) days notice prior to the action occurring
 - Claims will be recouped if the TCM has not approved the change prior to the service being provided
- Promptly notify the HCBS/FE Provider Manager if your agency/facility is having billing problems.

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Section 7:

Negotiated Service Agreements & Room and Board Rates

(only applicable to non-NF adult care home settings)

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- The Negotiated Service Agreement identifies services to be provided by the facility
 - Indicate which services and tasks will be paid for through the HCBS/FE program and therefore not the responsibility of the customer/family
- The TCM will review the Negotiated Service Agreement and functional capacity screen to verify:
 - The customer or family is not paying for services within the Room and Board rate that should be covered through the HCBS/FE POC, such as weekly housekeeping.
 - The level of need on the UAI is not far from the level of need on the functional capacity screen
- Room and Board consists of the room rate, raw food charges, and any non-covered services
 - Customers need to know what they are paying for within the room and board rate and agree, in writing, to the payment amounts
 - Rate should not fluctuate each month or fluctuate due to FE services not being provided
- HCBS/FE services that are authorized by the TCM to be paid through the POC may not be included in the Room and Board rate
 - KAR 30-5-308
- Facility services must be “unbundled” to allow the HCBS/FE POC to cover all authorized services
- Monthly Private Rate = \$ 3500 minus the following:
 - Bathing / dressing = \$ 400 (facility private rates)
 - Meal preparation = \$ 500
 - Housekeeping = \$ 300
 - Medication admin = \$ 450
 - Walking / mobility = \$ 200
 - ✓ Maximum room/board rate = \$ 1650 / month
- Monthly Private Rate = \$ 3500 minus the following:
 - Health Care Services = \$2000 per month
 - ✓ Maximum room/board rate = \$ 1500 / month
- Customers only have up to \$727 per month to pay towards room and board
- Families may supplement the room and board rate and/or pay for non-covered services
 - If so, the payment must be made directly to the facility. If it is put into the customer’s account then it will be counted as income at the next Medicaid review.

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Section 8: Interruption of Services

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- Interruption of Services, Planned Brief Stay, or Temporary Stay refers to a stay in Nursing Facility, hospital or rehabilitation hospital that is anticipated to be less than three months
- The services will not be paid while the customer is hospitalized, in a nursing home, or in any other situation where the customer is not available to receive the service.
 - This includes self-directed services even if the tasks are completed in anticipation of the customer returning home.
- “Same Day Services” are covered if:
 - HCBS services were provided the date of admission and provided PRIOR to admission
 - HCBS services were provided the date of discharge and provided FOLLOWING discharge
 - See billing instructions – page 7-3 in Provider Manual
- Personal Emergency Response and Medication Reminder are the only services that will be reimbursed during a Planned Brief Stay
- The customer’s case will remain open for the month of admission and the two months following admission
 - Example: Customer goes to hospital on June 20th, the HCBS/FE case will remain open until August 31st and shall close if customer doesn’t return to services
- TCM’s are to follow SRS eligibility worker’s lead as to the date the case closes, if necessary
- Providers are notified via the NOA of all service interruption dates
 - Be sure the billing person gets copies of all NOA’s, so appropriate billing may occur and overpayments will be prevented

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Section 9: Documentation Requirements

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- In the case of a post-payment review, reimbursement is recouped if documentation is not complete or does not meet the general documentation requirements provided in this manual and the requirements specific to the KMAP program and services provided.(provider manual 2700, general benefits 1/08, page 2-55)
- To verify services provided in the course of a post-payment review, documentation in the beneficiary's medical record must support the level of service billed. (provider manual 2700, general benefits 1/08, page 2-56)
- Documentation for the HCBS program must validate services billed were provided in accordance with the plan of care.(provider manual 2700, general benefits 1/08, page 2-56)
- "Documentation for any KMAP program created after the fact is not accepted in a post-payment review." (provider manual 2700, general benefits 1/08, page 2-56)
- Each FE service has specific requirements, such as:
 - Customer name (first and last) and signature
 - Attendant name and signature
 - Date of Service (MM/DD/YY)
 - Start time / End time or Time spent daily
 - Identify duties performed during visit
- Refer to the provider-specific manual, including its benefits and limitations section and recordkeeping requirements, for additional documentation requirements.
- Signature Limitations (posted 9/20/04)
 - Customer limitations make it necessary for them to have assistance with the signature requirement
 - Signing options:
 - Customer's signature
 - Customer's distinct mark
 - Customer using their signature stamp
 - Designated signatory
- Providers must keep updated on current requirements.
Visit <https://www.kmap-state-ks.us/public/providermanuals.asp> to view provider manuals.
- Upon a provider review being completed if any component of the documentation requirements is missing or illegible the entire units will be recouped.
- Be sure to note in the comments section the date of death, hospitalization, or nursing facility placement to explain why the documentation has not been signed by the customer.

**DOCUMENTATION SAMPLES may be found at <https://www.kmap-state-ks.us/public/forms.asp> under the "HCBS" heading.

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Section 10: Overpayment Chart

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The HCBS/FE program authorizes attendant care services on a weekly basis to allow the greatest flexibility in service delivery. For calculation purposes the plan of care is based on a 5-week month even though there are no months with 5 full seven day weeks.

The reason the 5-week plan is used is to allow payment for those providers that may provide services once or twice a week and there may be five opportunities to provide services. Some months will have five Sundays and five Mondays. For example, if a provider was providing services once per week in May they would be in the customer's home on 5/3, 5/10, 5/17, 5/24 and 5/31 for a total of five visits. Thus the need for plans of care to be calculated on a 5-week basis.

Providers may not bill for a full 5-week month, as no month like this exists, instead providers will bill based on services rendered. If a provider does bill the full 5-week month for the total units authorized per month the provider will end up with a considerable overpayment. This concept is shown on the overpayment chart.

Even if an assisted living facility provides services every day of the month within the weekly authorized units per week they will never bill the HCBS/FE program for the maximum units authorized for the month due to the week that ends and begins a month is split and therefore the services delivered must also be split.

For example, the overpayment chart for April indicates that all services authorized per week were provided which means for April there were 20 hours per week (Sunday – Saturday) rendered as authorized. The plan of care for 20 hours per week (for five weeks) equals 100 hours maximum. For all authorized services in April being provided the maximum that could be billed, based on providers' documentation in this example, would be 85.5 hours. If the provider billed for 100 hours then it would be an overpayment of 14.5 hours for that month.

In conclusion, because the plans of care are based on a 5-week month the providers are able to be paid accurately even though the maximum units billed per month will not equal the maximum units authorized on the HCBS/FE plan of care.

OVERPAYMENT CHART

March						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
29 Week 1 3.0	1 3.5	2 3.0	3 2.5	4 3.0	5 2.0	6 3.0
7 Week 2 1.5	8 3.0	9 3.5	10 2.5	11 3.0	12 3.0	13 3.5
14 Week 3 2.8	15 2.5	16 Went to Hospital 3.0	17 Hospital 0	18 Returned from Hosp. 1.0	19 4.0	20 1.7
21 Week 4 3.5	22 3.0	23 3.0	24 2.5	25 3.5	26 3.0	27 1.5
28 Week 5 3.0	29 3.5	30 1.5	31 3.0	1 3.5	2 2.5	3 3.0
*All hours authorized per week were provided in March with the exception of the week of hospitalization.						

March Hours provided: Week 1 = 17 hours Week 2 = 20 hours Week 3 = 15 hours Week 4 = 20 hours Week 5 = 11 hours 83.0 hours	POC: 20 hours/week X 5 weeks = 100 hours maximum 100 hours maximum - 83.0 hours provided 17.0 hours overpayment
April Hours provided: Week 5 (Mar) = 9 hours Week 1 = 20 hours Week 2 = 20 hours Week 3 = 20 hours Week 4 = 16.5 hours Week 5 = 0 hours 85.5 hours	POC: 20 hours/week X 5 weeks = 100 hours maximum 100 hours maximum - 85.5 hours provided 14.5 hours overpayment
May Hours provided: Week 4 (April) = 3.5 hours Week 1 = 20 hours Week 2 = 20 hours Week 3 = 20 hours Week 4 = 20 hours Week 5 = 6.5 hours 86.5 hours	POC: 20 hours/week X 5 weeks = 100 hours maximum 100 hours maximum - 86.5 hours provided 13.5 hours overpayment

April						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
4 Week 1 2.5	5 3.0	6 3.0	7 3.5	8 1.5	9 3.0	10 3.5
11 Week 2 2.8	12 2.4	13 3.9	14 3.2	15 2.7	16 3.0	17 2.0
18 Week 3 3.5	19 1.5	20 3.0	21 3.0	22 3.5	23 3.0	24 2.5
25 Week 4 3.0	26 2.5	27 3.5	28 1.5	29 3.0	30 3.0	1 3.5
Week 5						
*All hours authorized per week were provided in April.						

May						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
2 Week 1 3.0	3 3.5	4 2.5	5 2.0	6 3.0	7 3.5	8 2.5
9 Week 2 2.5	10 2.0	11 3.0	12 3.5	13 2.5	14 3.0	15 3.5
16 Week 3 2.5	17 3.5	18 2.0	19 3.0	20 2.5	21 3.5	22 3.0
23 Week 4 3.5	24 3.0	25 2.0	26 2.5	27 3.5	28 3.0	29 2.5
30 Week 5 3.0	31 3.5	1 2.5	2 3.0	3 3.5	4 2.5	5 2.0
*All hours authorized per week were provided in May.						

Section 11:

HCBS/FE Billing Information

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- References:
 - KMAP provider manual – General Billing
 - KMAP provider manual – specific FE service
 - Provider workshop handouts
 - KDOA training material
- Submit claim for units provided and documented (should not be based on units authorized)
- Bill with procedure code that aligns with service provided (refer to chart)
- Principle Diagnosis code for all FE services is 780.99
- Be sure and enter “1” for the diagnosis cross reference on the detail line
- Submit claim based on date of service
- Services for multiple months should be separated out and each month submitted on a separate claim
- If services were performed on *consecutive* dates, use the beginning date in the “from” and use the last date of service in the “to” fields
 - Use multiple detail lines when gaps in dates

Internet Claims Information:

- *Resubmit Claim* (Denied Claims only)
 - Access the denied claim from the ‘Claim Inquiry’ screen using the Claim Status Field
 - Open the denied claim needing correction by clicking the ICN link
 - Change information as needed, once this is completed, use TAB key to exit the field and click the “Re-Submit” button
- *Adjust Claim* (Paid Claims only)
 - Access the paid claim from the ‘Claim Inquiry’ screen using the Claim Status Field
 - Open the paid claim needing correction by clicking the ICN link
 - Change information as needed, once this is completed, use TAB key to exit the field and click the “Adjust” button
 - You cannot adjust a previously adjusted claim
 - You cannot adjust a claim that is over 24 months
- *Void Claim* (Paid Claims only)
 - Access the paid claim from the ‘Claim Inquiry’ screen using the Claim Status Field
 - Open the paid claim needing to be voided by clicking the ICN link
 - Scroll down to the bottom of the claim and click the “Void” button
 - A new window states the void is complete. This action creates an account receivable for the amount previously paid. The account receivable will be deducted from a future warrant.
- *Copy Claim* (Paid Claims only)
 - Access the paid claim from the ‘Claim Inquiry’ screen using the Claim Status Field
 - Open the paid claim to be copied by clicking the ICN link
 - The corresponding claim will display, scroll down and click the “Copy claim” button
 - New window with copy of claim will appear. Make changes as needed (dates, units, etc) and click the “Re-Submit” button

- *Common Claim Denials*
 - Client Obligation does not balance
 - SRS has to notify CME to update POC before the claim hits the PA
 - Beneficiary Ineligible for dates of service
 - This is serious – customer has lost HCBS or TXIX eligibility and the CME needs to contact SRS immediately. Claims will not pay unless resolved.
 - Provider not authorized for services billed
 - Procedure, dates or provider number on claim or PA is incorrect

CODES FOR THE FE WAIVER WITH KAMIS CODES

KAMIS:	Billing:	Specialty:	Description:	Unit Description:	Rate thru 6/30/06:	Rate effective 7/1/06:	Current Rate:
MADCX	S5101	410	Adult Day Care	1 u = 1 - 5 hours (2 u max per day)	1 u = \$20.67 2 u = \$41.34	1 u = \$21.50 2 u = \$43.00	1 u = \$21.93 2 u = \$43.86
ASTEX**	T2029 (S5165, W1386, W1375)	441	Assistive Technology	1 u = 1 purchase	1 u = purchase (lifetime max = \$7500)	1 u = purchase	1 u = purchase
ATCR1X	S5130	510	Attendant Care Services Level I	1 u = 15 minutes	1 u = \$3.18	1 u = \$3.31	1 u = \$3.38
ATCR2X	S5125	511	Attendant Care Services Level II	1 u = 15 minutes	1 u = \$3.52	1 u = \$3.66	1 u = \$3.73
ATCR3X	S5125 UA	511	Attendant Care Services Level III (eff. 11/1/11)	1 u = 15 minutes	n/a	n/a	1 u = \$4.12
ATCRUD	S5125 UD	511	Attendant Care Services – Self-Directed	1 u = 15 minutes	1 u = \$2.99	1 u = \$3.11 / \$3.17	1 u = \$2.71
COMPX**	S5135	518	Comprehensive Support – provider directed (eff. 10/1/08)	1 u = 15 minutes	n/a	n/a	1 u = \$3.38
COMPUD**	S5135 UD	518	Comprehensive Support – self-directed (eff. 10/1/08)	1 u = 15 minutes	n/a	n/a	1 u = \$2.71
FMSSDX	T2040 U2	530	Financial Management Service (eff. 11/1/11)	1 u = 1 month	n/a	n/a	1 u = \$115.00
TELEIX	S0315	531	Home Telehealth – install (eff. 10/1/11)	1 u = install (2 X yr)	n/a	n/a	1 u = \$70.00
TELEX	S0317	532	Home Telehealth – rental (eff. 10/1/11)	1 u = 1 day	n/a	n/a	1 u = \$6.00
MEDRX	S5185	509	Medication Reminder (eff. 1/1/05)	1 u = 1 month	1 u = \$15.00	1 u = \$15.60	1 u = \$15.91
NUEVX	T1001 (NPI)	515	Nurse Evaluation Visit	1 u = 1 face to face visit	1 u = \$37.10	1 u = \$38.60	1 u = \$39.37
MOHS**	DDDDD	n/a	Oral Health Services (eff. 4/1/10)	999 units	n/a	n/a	per fee schedule
PERMIX	S5160 (W1367)	252	Personal Emergency Response - install	1 u = install (2 X yr)	1 u = \$53.00	1 u = \$55.15	1 u = \$56.25
PERMX	S5161	253	Personal Emergency Response - rental	1 u = 1 month	1 u = \$25.00	1 u = \$26.00	1 u = \$26.52
MASCX**	T2025	513	Sleep Cycle Support	1 u = 6-12 hours	1 u = \$21.20	1 u = \$22.00	1 u = \$22.44
MAWMX	S5190 (NPI)	514	Wellness Monitoring	1 u = 1 face to face visit	1 u = \$37.10	1 u = \$38.60	1 u = \$39.37
n/a	T1017 U5 (NPI)	237	Targeted Case Management	1 u = 15 minutes	1 u = \$10.00	1 u = \$10.60	1 u = \$10.83
							(effective 7/1/07)
n/a	78099	n/a	Diagnosis Code for all HCBS services				
ACCC	ACCC	n/a	Acute Care Cost = \$159.00 (eff. 1/1/10)				

Note: KAMIS codes indicated with ** are currently suspended and only accessed if a crisis exception is approved by KDOA.

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Section 12: Miscellaneous Information

- **Acronyms**
- **Basic Information Fact Sheet**
- **Medical Necessity item listing (useful for those with a client obligation)**
- **List of available Case Management Entities (CME) for the HCBS/FE waiver**
- **Condensed definitions of how ADLs and IADLs are assessed**
- **Reasons for case closure**
- **Points to Remember**
- **Q & A**
- **Contacts**

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Acronyms

AAA	Area Agency on Aging
ADL	Activity of Daily Living
ALF	Assisted Living Facility
APS	Adult Protective Services
B/C	Boarding Care Home
CIL	Center for Independent Living
CME	Case Management Entity for FE Targeted Case Management
CSW	Customer Service Worksheet
FCS	Functional Capacity Screen
FE	Frail Elderly
HCBS/FE	Home and Community Based Services / Frail Elderly Waiver
HHA	Home Health Agency
HP	Home Plus
HP	HP Enterprise Services (fiscal agent)
IADL	Instrumental Activity of Daily Living
KAMIS	Kansas Aging Management Information System
KDHE	Kansas Department of Health and Environment
KDOA	Kansas Department on Aging
LOC	Level of Care (Long-Term Care Threshold Score)
MMIS	Medicaid Management Information System
NF	Nursing Facility
NOA	Notice of Action
NSA	Negotiated Service Agreement
PD	Physically Disabled Waiver
PIL	Protected Income Level
POC	Plan of Care
RHCF	Residential Health Care Facility
RN	Registered Nurse
SRS/HSS	Social and Rehabilitation Services / Human Services Specialist
TCM	Targeted Case Manager
UAI	Uniform Assessment Instrument

Basic Information Fact Sheet

- Documentation Requirements:(refer to the manual for specifics):
 - Identify the waiver service being provided
 - Customer name and signature
 - Attendant name and signature
 - Date of Service (MM/DD/YY)
 - Start time / End time; include AM/PM or use 2400 clock hours
 - Identify duties performed during visit
 - Providers must only bill for services that are rendered and documented in accordance with the NOA, CSW and Kansas Medical Assistance Program Provider Manual
 - Although for billing purposes the system POC is authorized on a monthly basis, the total hours for a beneficiary cannot exceed the daily or weekly approved amount as specified in the Customer Service Worksheet, if applicable, written POC, and Notice of Action.
- Forms:
 - Plan of Care – TCMs are required to send this form to providers, do not use it as a billing tool as it is based on a 5-week month
 - Customer Service Worksheet – informs the attendant which tasks to complete and the frequency and time allowed for completion
 - Notice of Action – informs the provider when to start services, how much service to provide, and any other pertinent information needing to be relayed to assist in service delivery
- Communication with TCMs:
 - Important to notify the TCM of changes needed in care (for facilities the changes should also be reflected on the Functional Capacity Screen)
 - Please notify the TCM if the customer is not home to receive services for example, they are in the hospital or if they are interfering with service delivery
 - Notify the TCM if the customer is falling behind or refusing to pay his/her monthly client obligation
 - Send customer a monthly statement
 - Team meeting with TCM, customer and provider if problems
- HCBS/FE Waiting List – ended April 26, 2004
 - TCM's are assessing and setting up services for customers once a referral has been made to the CME
- Questions about claims, denials, etc:
 - HP Customer Service unit at 1-800-933-6593
 - HCBS & TCM Program Manager for the Frail Elderly, at 785-296-0385 or Krista.Engel@aging.ks.gov (to assist in a more timely response please include your provider number, customer name, customer Medicaid number and date of service in question)
- Provider Website – <https://www.kmap-state-ks.us>:
 - Submit and inquire about claims
 - Check beneficiary eligibility
 - Check regularly for Provider Bulletins and Manual updates for HCBS/FE program changes
- Anytime there is a change of ownership or tax id number a new application must be completed and sent to the fiscal agent for processing and assignment of a new HCBS provider number.
 - Remember that all POCs are prior authorized for a specific provider so when there are changes to provider numbers you must notify the TCMs so they can update the POCs to ensure a smooth transition from one number to the next and not cause a delay in claims payment.

Medical Necessity Item Listing

(useful for those with a client obligation)

Revised 05-01-10

For a service or item to be allowed against spenddown, reduce HCBS obligation or to be used as a deduction for food stamps, it must be medically necessary. The guidelines in this document shall be used to determine if a service or item is medically necessary for purposes of these program services only. These guidelines are not appropriate for persons in nursing facility arrangements, as most of the items listed are considered routine for nursing facility consumers and should be covered by the NF (reference ACH Provider Manual, section 8400). Verification of the medical expenses is required in all situations.

A. Definition: Medical necessity refers to a health intervention that meets the following guidelines:

1. it is recommended by the treating physician or other appropriate licensed medical professional.
2. it has the purpose of treating a medical condition.
3. it provides the most appropriate supply or level of service, considering potential harms and benefits to the patient.
2. it is known to be effective in improving health outcomes.
3. it is cost-effective for the condition being treated when compared to alternative interventions.

B. Guidelines: Items and services covered by Medicaid are considered medically necessary. Other interventions may be medically necessary if the above conditions are met. The following guidelines apply:

1. The items must be prescribed by an appropriate licensed practitioner authorized by state law or other qualified health professional and be for a specific medical conditions. A medical practitioner cannot prescribe or establish medical necessity outside of his/her area of expertise (e.g. an optometrist can prescribe only eye-related services and medication).
2. The usual and customary rate is used when allowing any approved item or service. This is generally the amount the provider actually charged the individual. However, charges which appear excessive or beyond usual and customary rates may be submitted to central office for review. See item B (5) below.
3. The item is allowed at the quantity and duration indicated by the ordering medical practitioner. Excessive quantities shall be submitted to central office for review. Where lock-in providers exist, services and items provided or ordered by other like practitioners should be carefully reviewed, as they would generally not be allowable unless there were special circumstances, such as an emergency.
4. Verification of medical necessity is required. This may be done by a doctor's statement, prescription form or the Statement of Medical Necessity Form (Appendix Item P-2). The medical condition for which the item is necessary as well as the prescribed level or frequency of service or necessary dosage should be included. The duration of the needed intervention should also be noted.
5. A list of services and items that may be allowed follows in Section D. Allowances for services not exceeding the limitations described in the medical necessity documentation may be allowed.

6. If the item/service is not on the list, if a home modification exceeds \$500.00 or if allowable home health expenses exceed the limits, Kansas Health Policy Authority or EES central office staff determine if the expense is medically necessary. The determination considers the individual client's circumstances and needs. Requests for a determination shall include a description of the item or service, program involvement, and any other pertinent facts. The request and all supporting material should be sent to the following address:

Medical Assistance Manager KHPA;
Landon State Office Building, Suite 900
900 SW Jackson
Topeka, Kansas 66612

Food stamp requests are sent to Food Stamp Manager; SRS-EES Division at this address:

Docking State Office Building, Room 680-W
915 SW Harrison
Topeka, Kansas 66612
Or, fax the information to (785) 296-0146

7. Medicaid, Medicare and other applicable third party insurances must be billed and resolved prior to making any allowance.

C. Non-Medically Necessary Items: Certain items and services are never medically necessary, and are excluded from consideration. These include, but are not limited to, the following:

1. A sex change operation, cosmetic surgery, reversal of sterilization.
2. Alternative therapies, such as acupuncture, massage therapy, homeopathy, naturopathy, herbal therapies, magnet therapy, prolotherapy and hydrotherapies.
3. Household items that can be used for non-medical purposes such as air conditioners, humidifiers/dehumidifiers, water beds, food scales, weight scales, blenders, sunglasses (including prescription), heat lamps, vaporizers, hot water bottles, heating pads and exercise equipment.
4. Services provided by nursing facilities which are non Medicaid certified and those provided for a person who fails to meet level of care or provided during a period of ineligibility due to a transfer of property penalty period.
5. Community based services not provided by a medical practitioner or Medicaid -certified facility which have not been approved through the community-based screening team, except as noted in item 23 below.

Nonmedical expenses incurred in an assisted living or residential care facility, including room and board charges, are not medically necessary.

6. Over-the-counter drugs not prescribed by an appropriate licensed medical practitioner
7. Rubbing alcohol, antacids, laxatives, enzymes, mineral supplements, vitamins (except prenatal), distilled water, cotton balls, facial tissues, toilet paper, and band-aids, even if prescribed by a medical practitioner.
8. Food or food supplements and other special diets and aids, such as Medifast and Slim Fast.
9. Delivery and shipping/handling charges for pharmacy and durable medical equipment.

10. The premium for a non-Medicare medical discount card. If a client has a medical discount card, the discounted cost of allowable expenses (not the full cost) are allowable toward spenddown and as a food stamp deduction. (Also see D-26).

D. Medically Necessary Items or Services: The following items are allowable with proper documentation of medical necessity from an appropriate medical practitioner:

NOTE: For food assistance, proper documentation of medical necessity from an appropriate medical practitioner is only needed if the expense is questionable.

1. Adult day care- See item 23.
2. Alternating Pressure Pads and Pumps.
3. Assisted Living: For persons meeting HCBS level of care, costs of residing in an assisted living facility are allowable, with the exception of the portion attributable to room and board expenses (not applicable to food stamps).
4. Beds: Specialty beds such as hospital beds and specialty mattresses (e.g. water mattresses to relieve bed sores), bed rails, mattress covers.
5. Bedpans, urinals and basins.
6. Canes and Crutches.
7. Chiropractic Services.
8. Diapers and sanitary napkins, when used for incontinence, and other supplies such as underpads and chuxs.
9. Diet aids available through prescription (such as Meridia and Xenical). Diet supplements such as Ensure, Isocol or Carnation Instant Breakfast needed by an individual to maintain weight are allowable for medical only (also see C (8) above).
10. Dental services (e.g. examination, cleaning, extractions, dentures, denture realigning, fillings, orthodontics) not covered by Medicaid. For the PD, MRDD, and TBI (HI) HCBS waivers, services are allowable with certification from the case manager or ILC that services are not covered under the waiver.
11. Diabetic supplies -blood glucose monitors and supplies; including lancets, syringes and needles.
12. Dressing items (Applicators, tongue blades, tape, gauze, bandages, pads and compresses, ace bandages, Vaseline gauze, slings, splints, triangle bandages, pressure pads). Also see Item C (7) above.
13. Drugs- prescription/legend drugs when prescribed by a licensed practitioner authorized under state law. Over-the-counter/non-legend drugs and antiseptics when prescribed by an appropriate practitioner to treat a specific medical condition. Also see Items C (6) and (7) above.
14. (Service) Dogs and other Service Animals as defined by industry standards. Service animals are highly trained to meet the needs of the owner. Therapy, social or companion animals are not considered service animals. The cost of obtaining, replacing and maintaining the animal, including the costs of dog food and veterinarian bills.

15. Emollients, skin bonds or oils to prevent a condition from worsening.
16. Enema and enema equipment.
17. Eyeglasses or contact lenses prescribed by a physician skilled in eye disease or by an optometrist.
18. Feeding tubes - parenteral and enteral infusion pumps.
19. Foot cradles and foot boards.
20. Gel pads or cushions, such as Action Cushion.
21. Gloves (rubber or plastic); masks.
22. HCBS obligation for food stamps only. When the HCBS obligation is reduced due to other medical expenses, case should be taken to determine if the other expenses are allowable for food stamps.

For example: HCBS obligation is \$200 and is reduced to \$50 due to past due and owing bills that are determined not allowable for food stamps. The allowable obligation for food stamps is \$50.

23. Hearing aids and batteries.
24. Home health aide or attendant: Nursing services provided by a licensed practitioner are allowable in full for food stamp, also see the note in KEESM 7224. For medical, nursing services are allowed per item (25). Other home health services are allowable as follows:
 - a. For persons determined to meet LOC requirements for HCBS or institutional care, including those on a waiting list or serving a transfer penalty, services are allowable up to a monthly maximum of \$1000.00/month. These include services provided by a home health agency (such as Kelly Home Care Services) or other provider. Services provided by a spouse or if a minor child, a parent, are not allowable. Services must be itemized and must be consistent with the diagnosis/medical need.
 - b. For persons who do not meet LOC requirements, including those who have not yet been screened, medically necessary home health aide/attendant costs are allowable up to a maximum of \$250.00/per month.

Amounts in excess of these must be submitted to Central Office for review. In addition, the limits described above do not apply to food stamps.

25. Home modifications (including the cost of building a ramp for a wheelchair) of \$500.00 or less.
26. Hospitalization: inpatient or outpatient treatment.
27. Insurance Expenses: Premiums for health insurance policies, including major medical and limited policies (such as hospitalization, long term care, cancer, ambulance and dental plans) except for those plans which provide only lump sum settlements for death or dismemberment or continue mortgage or loan payments while the insured is disabled. Premiums for hospital indemnity plans which provide a specified per diem rate are allowable if the policy indicated the payments are intended to cover medical expenses. Medicare premiums not subject to buy-in are also allowable. For food stamps, only the portion of the premium for the elderly or disabled member may be allowed. If this amount cannot be readily determined, a prorated portion of the premium is allowed. Insurance copayments, coinsurance and deductibles are also allowable. Medicare cost sharing is covered in full for persons QMB eligible and is not allowable for those consumers.

28. I.V. stands, clamps and arm boards.
29. Intermittent Positive Pressure Breathing (IPPB) machines.
30. Irrigation solution, such as sterile H₂O or normal saline.
31. Lifts - Including chair and van lifts. Costs of the mechanism or repairs to the mechanism only.
32. Medicaid cost sharing. Medicaid copayments are allowable. For FS, the HCBS obligation, the PACE obligation and Working Healthy premium are allowable.
33. Medical equipment and supplies for use in a sickroom, including rental expenses.
34. Medical alert devices (e.g. LIFELINE) that can be activated in an emergency- the costs of purchase or rental, including installation charges. Pagers for persons awaiting an organ transplant are also allowable.

For medical only, medical ID bracelets and necklaces noting the individual's specific condition.
35. Nebulizers.
36. Nursing care provided by a licensed nurse (RN, LPN).
37. Oxygen supplies and equipment such as masks, stands, tubing, regulators, hoses, catheters, cannulas and humidifiers which are part of the oxygen apparatus.
38. Podiatry Services.
39. Prosthetics, including purchase, rental and repair.
40. Psychiatry.
41. Rehabilitation Services.
42. Sheepskins, foam pads.
43. Sleep apnea devices.
44. Smoking cessation treatments, such as Nicoderm and patches.
45. Stethoscopes, sphygmomanometers (blood pressure cuff) and other examination equipment.
46. Suction pumps and tubing.
47. Syringes and needles.
48. Targeted Case Management: TCM services provided by an entity authorized to provide TCM under the Kansas Medicaid program are allowable.
49. Telephone fees (monthly charges) for amplifiers and warning signals for persons with disabilities and the costs of typewriter equipment that is connected to the telephone for deaf persons.

50. Transportation and lodging to obtain medical treatment or services which are covered by Medicaid or are considered medically necessary, including to and from services included on the HCBS plan of care. Lodging costs may also be allowed for 1 attendant, if necessary. Waiting time is allowed for commercial providers only. Ambulance transportation is allowable.

Private vehicle mileage is allowable at the current state reimbursement rate for privately owned vehicles, including the enhanced rate for specially equipped or modified vehicles to accommodate a disability. Commercial transportation is allowable at the usual and customary rate of the provider.

51. TED Hose.
52. TENS units (transcutaneous electric nerve simulator), if used for pain relief only. Units used for weight loss are not allowable.
53. Traction and trapeze apparatus and equipment.
54. Vehicle modifications for a person with a disability- the costs of the modifications only.
55. Walkers.
56. Wheelchairs – maintaining, replacement and repair. A motorized wheelchair or scooter is allowable in lieu of a wheelchair.

Available Case Management Entities for the HCBS/FE waiver

Name	Address	Phone Number	Counties Served
Central Plains AAA	2622 W. Central Suite 500, Wichita, KS 67203	316-660-7298 1-800-367-7298	Butler, Harvey, and Sedgwick
Communityworks, Inc.	7819 Conser Place Overland Park, KS 66204	913-789-9900 1-866-429-6757	Anderson, Atchison, Brown, Coffey, Doniphan, Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Linn, Lyon, Miami, Nemaha, Osage, Sedgwick, Shawnee, Wabaunsee, and Wyandotte.
East Central Kansas AAA	117 South Main Ottawa, KS 66067	785-242-7200 1-800-633-5621	Anderson, Coffey, Franklin, Linn, Miami, and Osage
Gault Consulting and Family Services	P.O. Box 55 Leon, KS 67074	316-745-5061 (office) 316-250-4368 (cell)	Butler, Cowley, Greenwood, Sedgwick, and Sumner
Jayhawk AAA	2910 SW Topeka Blvd Topeka, KS 66611	785-235-1367 1-800-798-1366	Shawnee, Jefferson, and Douglas
Jensen, Patricia	701 N 2 nd Street Atchison, KS 66002	913-426-1431	Atchison, Brown, Doniphan, Jackson, Jefferson, Johnson, and Leavenworth
Johnson County AAA	11811 S. Sunset Drive Suite 1300 Olathe, KS 66061	913-715-8861 888-214-4404	Johnson
Legacy Case Services	Mail to: PO Box 9371 Wichita, KS 67277	316-722-5334 Fax: 316-722-3302	Barber, Butler, Cowley, Harper, Harvey, Kingman, Reno, Sedgwick, and Sumner
Life Transitions LLC	43 E 27th Hutchinson, KS 67502	620-259-7960 (office) 316-655-0542 (cell)	McPherson, Reno, and Rice
Mental Health Association of South Central Kansas	555 N. Woodlawn Street, Suite 3105 Wichita, KS 67208	316-685-1821	Butler, Sedgwick, and Sumner
North Central-Flint Hills AAA	401 Houston Manhattan, KS 66502	785-776-9294 1-800-432-2703	Chase, Clay, Cloud, Dickinson, Ellsworth, Geary, Jewell, Lincoln, Lyon, Marion, Mitchell, Morris, Ottawa, Pottawatomie, Republic, Riley, Saline, and Wabaunsee
Northeast AAA	526 Oregon Street Hiawatha, KS 66434	785-742-7152 1-800-883-2549	Atchison, Brown, Doniphan, Jackson, Marshall, Nemaha, and Washington
Northwest Kansas AAA	510 W 29th Street Suite B Hays, KS 67601	785-628-8204 1-800-432-7422	Cheyenne, Rawlins, Decatur, Norton, Phillips, Smith, Sherman, Thomas, Sheridan, Graham, Rooks, Osborne, Wallace, Logan, Gove, Trego, Ellis, and Russell
South Central Kansas AAA	304 South Summit Arkansas City, KS 67005	620-442-0268 1-800-362-0264	Chautauqua, Cowley, Elk, Greenwood, Harper, Kingman, McPherson, Reno, Rice, and Sumner
Southeast Kansas AAA	1 W. Ash Chanute, KS 66720	620-431-2980 1-800-794-2440	Allen, Bourbon, Cherokee, Crawford, Labette, Montgomery, Neosho, Wilson, and Woodson
Southwest Kansas AAA	240 San Jose Drive Dodge City, KS 67801	620-225-8230 1-800-742-9531	Barber, Barton, Clark, Comanche, Edwards, Finney, Ford, Grant, Gray, Greeley, Hamilton, Haskell, Hodgeman, Kearny, Kiowa, Lane, Meade, Morton, Ness, Pawnee, Pratt, Rush, Scott, Seward, Stafford, Stanton, Stevens, and Wichita
Stepping Stones Unlimited	501 Merchant, Suite A Emporia, KS 66801	620-342-6969	Chase, Coffey, Greenwood, Lyon, Marion, McPherson, Morris, Osage, Pottawatomie, Republic, Riley, and Wabaunsee.
The Caring Heart	7180 W. 107th St. Suite 26 Overland Park, KS 66212	913-901-8666 Fax: 913-901-8677	Johnson, Miami, and Wyandotte
Wyandotte-Leavenworth AAA	1300 North 78th Street, Suite #100 Kansas City, KS 66112	913-573-8531 1-888-661-1444	Wyandotte and Leavenworth

Cognitive Screening Condensed		
Screening Tool	Screening cue for assessor	Impaired if customer misses:
Orientation	Day of the week, month, year, President	2 or more
3-word recall	Pen, Car, Watch	1 or more
Spelling backward	Table (however customer spells)	any letter
Clock Draw	All #'s, spacing of #'s, hands at 10min after 11	any portion

Functional Assessment of ADLs and IADLs Condensed	
Code	Definition
(1) Independent	<ul style="list-style-type: none"> The customer is able to perform activity safely, adequately, appropriately, and within a reasonable time without assistance from another person. Customer is Independent if s/he performs the activity as stated, but does so with the use of an assistive device.
(2) Supervision needed	<ul style="list-style-type: none"> To perform the activity adequately, appropriately, safely, and within a reasonable amount of time, the customer needs: <ol style="list-style-type: none"> (1) Set-up assistance to perform some portion of the activity; or (2) Requires oversight, cuing or coaxing, including reminding to use assistive devices.
(3) Physical Assistance needed	<ul style="list-style-type: none"> To perform some aspects of the activity adequately, appropriately, safely, and within a reasonable time, the customer requires some hands-on assistance, but is: <ol style="list-style-type: none"> (1) Able to physically perform some components of the activity; or (2) Although customer has limited physical participation, they are able to direct the activity, in other words make known how they prefer the activity be performed.
(4) Unable to Perform	<ul style="list-style-type: none"> The customer is unable to participate in this activity in any significant manner due to cognitive, physical, and/or mental health limitations and needs total assistance.
ADL's	Assess the customer's ability to:
Bathing	<ul style="list-style-type: none"> Take a full body bath or shower at least once a week or more frequently to prevent odor or skin health issues; and Set-up and put away bathing supplies, <i>i.e.</i> towel, washcloth, soap, shampoo, assistive equipment, or long handled brush and adjust bath bench or other assistive devices; and Transfer in and out of the tub or shower; and Turn on the water and adjust the water temperature; and Wash and dry all body parts, including back, feet, and hair. <p><i>Coding Clarification: Code as (3) "Physical Assistance" if the customer is consistently unsteady or has fallen more than once while bathing in the last month.</i></p>
Dressing	<ul style="list-style-type: none"> Change clothes often enough that the customer appears clean and is odor free; and Select, obtain, and set-up clothing for dressing; and Select clothes that are safe and appropriate for the temperature and usual activities inside and outside the home, not special occasions; and Put on, adjust, fasten (including buttons, snaps, zippers, ties, etc.) and take off all items of clothing; OR the customer has and wears adapted clothing that allows s/he to dress for most public occasions without needing to use buttons, snaps, ties, etc.; and Put on and remove prosthesis and/or medically needed clothes or devices, such as TED hose.
Toileting	<ul style="list-style-type: none"> Transfer on and off the toilet; and Complete bowel/bladder elimination; and Cleanse self and adjust clothing; and Manage incontinence and supplies, bedpan, commode, ostomy and catheter. <p><i>Coding Clarification: Code as (3) "Physical Assistance" if the customer is consistently unsteady or has fallen more than once while toileting in the last month.</i></p>
Transferring	<ul style="list-style-type: none"> Move between surfaces, <i>e.g.</i> to and from the bed, chair, wheelchair, or to a standing position; and Rise from a sitting/laying position; and Recline to a sitting/laying position <p><i>Coding Clarification: Code as (3) "Physical Assistance" if the customer is consistently unsteady or has fallen more than once while transferring in the last month.</i></p>
Walking/ Mobility	<ul style="list-style-type: none"> Move within all locations of his or her living environment to accomplish ADLs; and Ambulate safely from one area to another; and Place or set-up assistive equipment in usable location; and Obtain equipment and use the equipment safely and effectively at all times; and Maneuver cane, walker and/or wheelchair, if needed. <p><i>Coding Clarification: Code as (3) "Physical Assistance" if the customer is consistently unsteady or has fallen more than once while walking/mobility in the last month.</i></p>
Eating	<ul style="list-style-type: none"> Prepare food by cutting into bite size pieces, chopping, or pureeing, buttering bread, opening single serving containers, and pouring liquids; and Transfer food and drink from plate or cup to mouth; and Chew and swallow safely; and Manages tube feeding without assistance, if fed through a tube.

IADL's	Assess the customer's ability to:
Meal Preparation	<ul style="list-style-type: none"> • Plan, prepare, and serve a meal; and • Safely use stove or microwave to heat or cook foods; and • Open containers, turn stove on and off, use can opener; and • Opening the ingredients, peeling, cutting, chopping, measuring, baking, and/or cooking the meal; and • Follow a doctor prescribed diet, when applicable (i.e., low sodium, low sugar, or low fat.) <p><u>Coding Clarification:</u> Code (2) if the customer only needs set-up to prepare a meal, which includes putting out pans and placing ingredients on the counter.</p>
Shopping	<ul style="list-style-type: none"> • Develop a list of needed items, go to store, locate items to be purchased, place them in a cart, or shop effectively by phone or on-line for all items; and • Carry five pounds of canned goods or bulky items; and • Move purchased items from vehicle or doorway into home.
Money Management	<ul style="list-style-type: none"> • Budget according to income or personal funds; and • Deposit checks and manage account balances; and • Evaluate the accuracy/legitimacy of bills received; and • Pays bills and pays for merchandise by check, cash, credit/debt card, money orders or online payments; and • Tracks expenditures so as not to overdraw accounts or incur unintended debt. <p><u>Coding Clarification:</u> Code as a (2) "Supervision" if the customer needs oversight/cuing to ensure the tasks in the definition are completed. This includes:</p> <ul style="list-style-type: none"> • Sorting mail; • Providing advice on which bills to pay; • Reviewing the checkbook (not physical act of balancing it); • Assuring the customer/providing guidance or advice. <p>Code as (3) "Physical Assistance" if the customer needs assistance to ensure the tasks in the definition is completed. This includes:</p> <ul style="list-style-type: none"> • Writing checks; • Balancing the checkbook (not just reviewing it); and • Preparing and maintaining a system to track expenditures. <p>Code as (4) "Unable to Perform" if the customer has a conservator or is not involved in money management decisions.</p>
Transportation	<ul style="list-style-type: none"> • Safely drive own car OR has available and can arrange for and use private or public transportation; and • Able to enter, adjust position, and leave the vehicle without assistance from another person (may use assistive devices); and • Manage getting assistive equipment, if needed, into and out of the vehicle. <p><u>Coding Clarification:</u> Code as (2) set-up, if the customer only needs someone to arrange transportation.</p>
Telephone	<ul style="list-style-type: none"> • Obtain needed telephone numbers; and • Dial the phone; and • Answer and hang-up the phone; and • Converse over the phone; and • Arrange and schedule appointments. <p><u>Coding Clarification:</u> Code as (2) "Supervision" if the customer needs oversight/cuing to ensure tasks in the definition are completed. This includes looking up phone numbers in the phone book, and/or providing a small list of frequently called numbers because the customer can not find them in the phone book. Code as a (3) "Physical Assistance" if the customer needs physical assistance to ensure the tasks in the definition are completed. This includes dialing the phone, answering and/or hanging up the phone, and arranging or making calls to schedule appointments. Code as (4) "Unable to Perform" if the customer is not able to converse on the phone.</p>
Laundry, Housekeeping	<ul style="list-style-type: none"> • Determine when the clothes need to be washed and complete all the laundry steps, e.g., takes clothes to wash area, determines the amount of detergent needed, able to properly set the washing machine; and • Place clean clothes into storage/closet area; and • Perform routine tasks, e.g., bed making, putting items away, dishwashing, and taking out trash; and • Keep pathways in the home clear for mobility; and • Understand methods to kill germs and bacteria; and • Sweep, vacuum, and mop.
Medication Management, Treatment	<ul style="list-style-type: none"> • Obtain medication from containers; and • Determine the proper dosage of the medication and prepare it (cut pills in half or draw up medication in syringe if necessary); and • Administer own medication; and • Remember to take medication as prescribed; and • Recognize possible side effects of the medications when this is essential for safety; and • Set up materials for treatments and conduct treatment procedures; and • Store medication correctly and understand risks of taking outdated medication; and • Recognize when medication is running out, seeks refills, or follows-up with provider. <p><u>Coding Clarification:</u> Code as (2) "Supervision" if the customer can administer his/her medication once it is set-up in a pill-box, the pill container is opened, or he/she is reminded or cued to take medication. Code as a (3) "Physical Assistance: if the customer must have the medication handed to him/her.</p>

Reasons for TCM to initiate case closure:

- Loss of Medicaid financial eligibility.
- Customer no longer meets HCBS/FE functional eligibility criteria.
- Lack of cooperation to the point that the customer and/or family substantially interfere with providers or the CMEs ability to provide services (e.g., refusing providers, inability to get along with providers, or inappropriate customer and/or family behaviors). Other options must be explored prior to termination of services.
- Change in medical condition where health and welfare needs cannot be met with HCBS/FE waiver services.
- Customer fails or refuses to pay the monthly client obligation as per agreement and the provider is unwilling to continue services and no other provider can be found.
- Customer fails or refuses to sign or abide by the POC or CSW.
- Providers of HCBS/FE services are no longer available or the customer refuses service(s) on the POC.
- Customer is determined to be no longer safe in his or her own home.
- Customer chose to terminate services, including moving out of state.
- Customer is a PACE participant.
- Customer's whereabouts are unknown (e.g. post office returns mail to the agency indicating no forwarding address).
- Customer enters a nursing facility and is not expected to return to the community.
- Customer dies.
- Customer refuses to sign the "Customer Code of Conduct" (SS-043).
- Customer, family member, or other person present in the household committed a Level I Safety Offense as specified in Section 3.1.11 and did not comply with the action plan to correct the problem.
- Customer, family member, or other person present in the household committed a Level II Safety Offense as specified in Section 3.1.11.

Reasons providers may refuse or terminate services:

(per the KMAP HCBS application)

Kansas Medical Assistance Program HCBS Provider Certification Statement (06/08)

As a KMAP HCBS provider, I agree to adhere to the standard of quality of service which is implied by my enrollment as a provider of these services. I will be available for provision of services to eligible KMAP beneficiaries as prescribed in the individual beneficiary's plan of care.

I will agree to refuse no referrals for services, except under the following conditions:

- If the beneficiary, the beneficiary's family, or both substantially interferes with the provider's ability to deliver services, including refusing service and interfering with the completion of work
- If a possibility exists of the beneficiary physically harming the provider or where violence has been previously noted
- If the beneficiary or a member of the beneficiary's family makes sexual advances, demonstrates sexually inappropriate behavior, uses sexually inappropriate language in the presence of the provider or any combination of such actions

If services are to be terminated by the provider, written notice of termination shall be given to the beneficiary or the beneficiary's family, except in instances of death or institutionalization. The notice shall be served by delivering a copy of the notice to the beneficiary and the case manager or by mailing a copy of the notice to the beneficiary at the beneficiary's last known address. Notice shall be served at least 30 calendar days prior to the effective date of the termination, except in cases of violent or sexually inappropriate behavior. The notice shall include the reasons for and the effective date of the termination.

HCBS/FE Points to Remember:

HOME HEALTH AGENCIES

- Agencies should never start services without first receiving a Notice of Action authorizing the start of service(s).
- Agencies cannot change the Plan of Care; they must work with the TCM for authorization of any needed change(s) identified by the agency or customer.
- If you have questions regarding what tasks have been authorized, call the TCM and have them provide clarification of the Customer Service Worksheet.
- TCMs write Plans of Care on a weekly basis to allow for maximum flexibility in serving the customer.
- If written on a daily basis, the agency must provide the specified number of hours each day and if a customer requires more time than has been authorized, the provider will not be able to bill the additional time over what has been authorized daily.
- The agency must document the HCBS/FE services provided to the customer each visit.
- The Provider Manual specifies what documentation is to be completed.

HCBS/FE Points to Remember:

AL/RHCF, HOME PLUS, AND BOARDING CARE HOMES

- The facility must have a **Negotiated Service Agreement**, which outlines the services that will be provided by the facility, as well as identifying which tasks/services HCBS/FE will reimburse the facility for providing.
- There cannot be duplication of the services paid through HCBS/FE and the services paid through the Room and Board rate.
- Facilities should never start or provide services without first receiving a Notice of Action authorizing the service(s).
- Facilities cannot change the Plan of Care; they must work with the TCM for authorization of any needed change(s) identified by the facility or customer.
- The facility and customer are responsible for working together to negotiate the room and board rate. The Plan of Care cost is **separate** from the room and board rate.
- Room and Board – covers room charge and raw food costs as well as any non-covered services.
- HCBS/FE Plan of Care – covers authorized HCBS/FE services.
- If you have questions regarding tasks authorized, call the TCM for clarification of the Customer Service Worksheet.
- TCMs write Plan of Cares on a weekly basis to allow for maximum flexibility in serving the customer.
- If written on a daily basis, the facility must provide the specified number of hours each and every day and if a customer requires more time than is authorized, the provider is not able to bill the additional time over what has been authorized daily.
- The facility needs to document the HCBS/FE services provided to the customer on a daily basis.
- The Provider Manual specifies what documentation is to be completed.
- Facilities may limit the number or percent of HCBS/FE customers. Be sure it is clearly written in policy and applied consistently.

HCBS/FE Points to Remember:

GENERAL PROVIDER INFORMATION

HCBS/FE customers are responsible for selecting service provider(s). The customers must also select the method of service delivery. For Attendant Care and Comprehensive Support the customer must choose either self-directed or provider directed care:

- Self-Directed Care** – This option allows the customer to direct the eligible services which have been determined by the customer and the TCM to be essential to the maintenance of their health and welfare.
- Participation in this option allows the individual to direct all or part of the eligible services provided.
 - The customer is responsible for referring for hire, training, and firing their Attendant or Support Worker.
 - The customer is also responsible for creating a back-up system for when their regular Attendant or Support Worker is unavailable.
 - The Attendant and Support Worker must enroll with a Home Health Agency or Center for Independent Living to act as their payroll agent.

- Provider Directed Care** – The customer is responsible for selecting service provider(s).
- The service provider is responsible for staffing the needs of the customer as set forth in the Notice of Action and Customer Service Worksheet.
 - It is the responsibility of the provider to create a back-up system for the customer if the regularly scheduled Attendant or worker is unavailable.

Client Obligation is the amount determined by the Department of Social and Rehabilitation Services (SRS) to be paid to the provider by the customer on a monthly basis.

- Once notified through a Notice of Action that a client obligation exists
- The provider must collect the client obligation from the customer (as long as the services provided exceed the amount of the client obligation).
- The client obligation will be automatically deducted from the claim as it processes

PLEASE NOTE: The Plan of Care is **not** to be used as a billing tool. Plans of Care are figured on a 31-day or 5-week month.

- There are only 7 months with 31 days, and there are **no** months with 5 weeks.
- If the dollar amounts on the Plan of Care are billed on a monthly basis, this will ultimately result in an overpayment and recoupment.
- Providers must **ONLY** bill for the services that are documented as rendered in accordance with the Notice of Action, Customer Service Worksheet and Kansas Medical Assistance Program Provider Manual.

Although for billing purposes the system POC is authorized on a monthly basis, the total hours for a beneficiary cannot exceed the daily or weekly approved amount as specified in the Customer Service Worksheet, if applicable, written POC, and Notice of Action.

Questions & Answers:

- 1) **Are call lights and medical response units (that are one and the same unit) used to call the nurse's station when pushed allowed to qualify for Personal Emergency Response reimbursement?**

Yes, this system would be able to qualify for reimbursement, as long as the customer is able to wear the medical response button and press it without reaching for the call light button. If the units are pre-installed, HCBS will not pay for installation.

- 2) **What items/services qualify to possibly reduce a customer's obligation?**

Please refer to the section "Medical Necessity Listing".

- 3) **What options does a provider have when the hours per task provided do not match the hours per task as authorized on the Customer Service Worksheet?**

KDOA understands that there will be times when customers refuse services or are not available to receive services. In these limited instances it would be acceptable to spend the unused time for another task. Documentation would need to reflect why authorized tasks were not provided and what task was provided instead. If this is a continuous situation, KDOA would expect that when the time authorized is not matching the needs of the customer, the TCM would revise the Customer Service Worksheet to reflect appropriate tasks and times needed.

- 4) **What can the provider do if they feel the TCM is not correct in what they authorize for services to allow for good care?**

The provider needs to discuss their concerns with the TCM, then the CM Supervisor, then the Director, then KDOA. Try to resolve the issue beginning at the lowest level and work up if no resolution is found.

- 5) **Some facilities deal with several TCMs and each has a different slant on the same issue. Is it possible to limit the number of TCMs per facility?**

If there are inconsistencies with standard times from time studies, work with the TCMs to discuss why there are inconsistencies in times authorized. However, POC's are written based on need, POC's will reflect differing times allowed due to differing needs. No, it is not possible to limit the number of TCMs. Case management entities have the option to develop their CM's client list as they choose KDOA doesn't dictate this.

- 6) **If a provider overbilled for a month, what should be done?**

The provider needs to follow the overpayment/adjustment process determined by the Fiscal Agent.

- 7) **Are HCBS/FE services available to people living in Independent Apartments?**

Yes, HCBS/FE services are allowed to be provided in the housing option of the customer's choice, with the exception of Nursing Facilities.

- 8) **Can the time a dietary manager spends ordering groceries be used as part of the shopping time?**

No, ordering groceries is an administrative cost. Individualized shopping for customers is allowed.

9) Is it correct that if a customer qualifies for Medicaid they do not automatically qualify for HCBS Medicaid?

Correct, Medicaid and HCBS Medicaid are two separate programs that have different requirements. Your local SRS office can explain the difference in the programs.

10) How much money can the resident keep for their personal needs?

This amount will vary depending on the amount negotiated between the customer and the facility.

11) Does KDOA expect the room and board rate to be the same for all HCBS customers?

No.

12) Will room and board rates vary based on the customer's ability to pay?

Yes, if the facility is willing to negotiate the rate.

13) Can the facility limit the number or percent of HCBS/FE customers they accept without jeopardizing their HCBS/FE enrollment?

Yes, facilities must follow KDOA licensing regulations and have any limitations of HCBS/FE customers in written policy.

14) Is it acceptable to bill a customer for room hold days, if they are in the hospital or NF for a planned brief stay?

Yes, refer to K.A.R. 26-39-102(k)(1-3).

15) When does the Protected Income Level Change?

It varies depending on when the Legislature approves a change.

16) Can an AL/RHCF or Home Plus provide services in the community and bill HCBS/FE for the services rendered?

No. For the HCBS/FE program, KDOA requires that facilities provide services for which they are licensed. As a licensed Home Plus, ALF, or RHCF you may provide and bill only those services rendered within the facility. If a facility wishes to provide HCBS/FE services in the community, they must establish a state-licensed Home Health Agency.

17) What does a provider need to do when a customer goes to the hospital or nursing home?

The TCM must be notified immediately anytime the customer is away from their home for more than 24 hours. This includes, but is not limited to, hospitalizations, rehabilitation stays, vacation, and time away with family. HCBS/FE services may not be provided or billed if the customer is away from their home.

18) Can family assist with payment of HCBS/FE services?

No. Services that are on the HCBS/FE POC may not be paid for by an organization, agency, family, customer, or other individual per KAR 30-5-308.

19) May a facility charge the customer or family the difference between the HCBS/FE POC and the facility's private rate?

No. This would be considered supplementation of HCBS/FE services which is not allowed per KAR 30-5-308.

20) May a family pay the customer's room and board rate?

Room and Board is not a covered service and since the POC is figured separately from the room and board the family, if able and willing, may assist with payment of room and board as long as it is paid directly to the facility.

21) Is the amount a provider is paid for HCBS/FE services the same each month?

The POC is not a billing tool, it shows the maximum number of units of service authorized. Only services that are provided and documented can be billed and paid.

22) In regards to the comprehensive support service can leisure activities be in the community?

Activities and the supportive supervision need to be provided in the customer's home setting and not out and about in the community.

23) In regards to the nurse evaluation visit service, can FE attendant care services be provided prior to the nurse evaluation visit being completed?

Best practice is to complete the nurse evaluation visit prior to starting services due to the purpose of the nurse evaluation visit.

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